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It is a scientific journal directed to the professional disciplines engaged in care, treatment, and rehabilitation of mentally ill and retraded patients as well as to those engaged in Professional research and preventive work in the field.

This journal is intended to be inclusive rather than exclusive and is not meant to be regarded as simply a house organ of the North Carolina State Department of Mental Health.

It is hoped that the journal will reflect the broad-based philosophy of psychiatry current and will draw on areas reflecting the total spectrum of psychiatric and neurologic thought, program and research.

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(Notice to contributors — see inner back cover)

NORTH CAROLINA JOURNAL OF
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EDITORIAL

Genesis of a Journal

This marks the first issue of what we hope will be the genesis of a journal which will provide a medium in the state for communication concerning mental illness and mental health on a broad interdisciplinary scale. Furthermore, this journal is intended to be inclusive rather than exclusive and certainly is not meant to be regarded as simply a house organ of the North Carolina State Department of Mental Health. It is hoped that the journal will reflect the broad-based philosophy of psychiatry current and will draw on areas reflecting the total spectrum of psychiatric and neurologic thought, program, and research.

Contributors need not be psychiatrists, neurologists or M.D.'s but should be involved in some aspects of program, whether clinical, educational, or research, pertinent to mental health or mental illness.

Notice to contributors: Manuscripts offered for publication in the *Journal of Mental Health* should be submitted in the original, typed on bond paper and double spaced with 70 characters per line. Footnotes, bibliographical references, quotations, etc. should also be double spaced and the use of footnotes minimized.

References to books and journals should be numbered consecutively in the bibliography on a separate page at the end in the order in which they appear in the manuscript. References should be limited to those used by the author in the preparation of the article and kept to a minimum.

Corrections and galley proofs which authors receive may apply only to printers' errors. The cost involved in changing the text other than printers' errors makes this prohibitive.

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Headache

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Patients with a complaint of headaches sometimes seem innumerable, although headache is a surprisingly *uncommon* complaint within an institutionalized hospital population. Patients with headaches, as those with nervousness, constipation, and similar disorders, can be cured or comforted, but at times a doctor can only hope to understand the problem. The physician's understanding will depend first on his skill as a historian, secondly, on his theoretical concepts of headaches, and thirdly, on his patience and persistence. This review is aimed at the second feature, and is not intended as a test of the third.

Evaluation of the History. The history begins when the patient is first seen. A patient who flutters long artificial eyelashes and has "more headaches than anyone can bear" not only often lacks organic disease, but may require rearrangement of the day's schedule. On the other hand a patient who is vomiting, turns away from the light, and irritatedly mutters "migraine" needs more treatment than interview. Several historical features are often overlooked. As with any pain you should explore: (1) onset (time, triggering events); (2) the character of the pain (length, intensity, patient's description); (3) associated features (gastrointestinal, genitourinary, etc.); (4) useful treatment (what the patient does, what medicine does, what the family does); (5) things that worsen the pain (at this point one can expect to hear a recitation of the failures of other doctors). A few physicians allow the patient to tell the story in their own words. All physicians should remember to interview the family and family doctors who can add to, or subtract from, the headache history offered by the patient.

MECHANISMS OF HEADACHE

Wolfe reports that brain substance, dura, and skull bone are relatively insensitive to pain. Pain can be produced by stimulation of the venous sinuses, meningeal and other large intracranial arteries, or stimulation of the dural floor of the anterior and posterior fossa. Pain from the posterior fossa is usually referred to occipital and cervical areas along the

ninth and tenth cranial nerves. Stimulation above the tentorium produces pain referred to the forehead, temple, or parietal areas along the fifth cranial nerve distribution. Almost all the extracranial structures, such as scalp, nasal cavities, and teeth, are pain sensitive, and pain from these areas is likely to be localized near the site of irritation.

The following pathophysiologic mechanisms are considered responsible for most commonly occurring headaches: 1. *Dilation of intracranial or extracranial arteries.* Pain can be produced by arterial distention resulting from intravenous injection of histamine, the use of a human centrifuge or other measures. Similar arterial dilatation is considered responsible for the pain in migraine and other vascular headaches. Such types of pain are usually relieved by measures which reduce arterial distention. These measures include compression of the carotid artery, increasing spinal fluid pressure, or compression of the jugular vein. Straining during the Valsalva maneuver eases the pain, which returns in an augmented fashion as soon as the Valsalva maneuver is completed. Both extracranial vascular headaches and intracranial vascular headaches are reduced by lowering the blood pressure. Headaches due to vasodilatation may also be relieved by the vasoconstriction produced by ergotamine derivatives. The most common vascular headaches seen by physicians are migraine and hypertension headaches; but the most common type which occur are those seen in association with fever, hunger, seizures, or following a Saturday binge.

2. Traction upon intracranial structure. Displacement of the pain sensitive structures which stabilize the brain is considered the cause of pain produced by brain tumor and other expanding intracranial masses. This type of headache is a deep aching pain which is non-throbbing, and which may be associated with sudden vomiting without severe nausea. The location of headaches resulting from tumor is similar to the location of the tumor. Headaches due to traction are made worse by head jolt, straining, and other factors which produce fluctuations in arterial and intracranial pressures.

3. Combined traction upon and dilatation of intracranial vessels. This occurs in special situations such as following removal of spinal fluid in an erect subject.

4. Inflammation of cranial structures. Blood, pus or air in the subarachnoid space is inflammatory and may be associated

with severe headache. This is perhaps not a separate mechanism of headache, and some authors feel that the only major mechanisms of intracranial headaches are (a) blood vessel dilatation or (b) traction on pain sensitive structures.

5. Contraction of the skeletal muscles of the head and neck. This is the standard TV "take my pain reliever" headache, in which machines seem to squeeze, push, or twist the neck muscles. These pains (as the ads suggest) occur in the setting of emotional tension.

6. Pain spread from other structures. There can occasionally be an overflow of referred pain into the face, for example, in the cardiac patient. Children have for generations been aware of "ice cream" headaches which consist of a mid-frontal pain caused by cold stimuli in the roof of the mouth.

7. Psychogenic headaches. Headaches may be seen in depression, schizophrenia, or as a conversion reaction. In addition to headaches associated with psychosis, many headaches in emotionally unstable persons are found to be hard to define, are bizarre in type, and are not amendable to therapy by a neurologist.

Several Special Types of Headaches

Although headaches can be classified in a list almost as innumerable as the patients, most recent classifications have tended to categorize the headaches into 10 to 20 different types. Several of these types deserve special emphasis to the psychiatrist; others, such as the cranial neuralgias, are very infrequently seen by practicing psychiatrists.

1. Migraine Headaches. Migraine headache is a type of "periodic pain associated with paresthesias, photophobia, and puking." Frequently, migraine headaches are preceded by blindspots or bright dots, numbness, or aphasia, all of which are usually related to the vasoconstriction which precedes painful dilatation of the vessels. The pain is a severe, throbbing discomfort which appears as the paresthesias disappear. Gradually the pain may become bilateral and usually develops into a steady dull ache. Migrainous pain is often associated with vomiting, photophobia, and intense irritability. Many patients with migraine have a positive family history for the disorder.

One particular migraine variant known as "cluster headache" has been reported from Duke University. This type of

pain is unilateral, in or behind an eye, and is extremely severe. Episodes are of short duration, usually lasting less than an hour. The patient may be noted to have a stuffy nose, and a red teary eye. At times vomiting and a positive family history is seen with these patients, but less typically than with classical migraine. The migrainous patient usually lies down in a dark room, but patients with cluster headaches are restless due to the discomfort. Cluster headaches often waken the patient at night, something that is uncommon with classical migraine. The name "cluster" comes from the fact that the headaches tend to come in bursts of one or more attacks per day for several days with free intervals lasting for weeks or months.

Another type of headache of special interest is the headache following a lumbar puncture. This occurs in approximately 50% of patients who have a lumbar puncture and may last for hours or days. The pain is almost always relieved by lying down, and is aggravated by sitting or standing. It is doubtful that bedrest immediately following an LP prevents these headaches.

The psychiatrist often sees mixed headaches containing a vascular component as well as features due to contraction of the skeletal muscles of the head and neck. Headache due to muscle contraction is analogous to muscle spasms that occur with bone fractures or abdominal infections. The pain is likely to be a deep steady ache described as tightness, pulling or tenderness. Apparently caused by emotional tension, it can also be due to cervical root irritation, postural strain, or noxious skin stimuli. Heat, rest, mild analgesics, or a vacation usually suffices for treatment in most of these patients. Indeed, most patients with muscle tension headaches never seek relief from a physician.

Personality. It has been said by Lyle and Osler that in some instances it is more important to understand what man has the disease than to understand what disease the man has. Many writers have felt that this is true of patients with migraine, and many of the comments make migrainous patients sound like most unpleasant people. The women are termed "house proud", frigid, or obsessive-compulsive about cleanliness. They are reluctant to express anger and unable to do as well with informal social affairs as with formal and planned arrangements. The migrainous males are described as cool, orderly, and likely to be attentive to details. Frustration may

become a prominent feature in middle age as the job duties become more complex and adjustment patterns break down. Among actual patients, however, there is no universal personality pattern which is typical. They are often orderly, conscientious, ethical, and hardworking, but such qualities do not invariably make a patient unpleasant. The one universal quality that migrainous patients seem to have is an extremely high level of activity from early life on into middle age.

Depressed patients commonly have headaches which at times are their presenting complaint. The exact etiology of the headache with depression is obscure since eating, sleeping, weight, muscle tone and bowel function are all changed in some depressed patients. Headaches with depression may have a diurnal variation and are often worse in the morning. The pain is often incessant and poorly defined, but is frequently "like a band" around the head. The voice and facies of the patient may convey depression and at times the physician is sure the affect is contagious. The most common cause of onset of persistent headaches in adult life is probably depression or other emotional unrest, but each patient with dull, atypical headaches has to be thought of initially as a brain tumor suspect.

Physical Examination of Patients with Headaches. In addition to neurologic and medical evaluation, several special diagnostic measures are useful for patients with headaches. Cough and strain as in the Valsalva maneuver may indicate whether a vascular headache is present. Sudden head jolt from side to side often elicits pain in a vascular headache, but may also give unilateral pain when a subdural hematoma or brain tumor is present. Light percussion of the head can occasionally elicit focal pain from an organic lesion. Auscultation of the head may reveal a bruit, particularly since occlusive carotid artery disease can present as painful temporal or neck discomfort with bruits, and since rare patients with migraine have angiomatous malformation. A trial of intravenous or intramuscular gynergen is occasionally useful in adding support to the impression of a vascular headache. As a rule, none of the physical measures for diagnosis is as useful as a good history from the patient.

Note: The text on headaches by Harold Wolfe is the classical work in the field. Notes of Dr. Albert Heyman also assisted in this summary.

The Nurse's Role in Handling Severe Anxiety and Panic States

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As a nursing care problem, severe anxiety and panic have long been recognized by nursing educators as a psychiatric emergency. Students of nursing are taught that this degree of anxiety can be triggered off from two main sources: threats to biological integrity and threats to the self-system of the personality. Due to the disorganizing effects of severe anxiety on the personality and the pathological patterns of handling this most terrifying affect, the nurse is taught to prevent this degree of anxiety from occurring if possible and to reduce it immediately when it is observed.

Patients experiencing severe anxiety or panic may appear to the nurse lost, overtly angry, loosely associated, completely dependent, shaky, physically ill, overactive, intent on "silly little things", mute, frozen to the spot or any other of a number of patterns of behavior. In speaking, a patient may appear incoherent, unaware of his environment and unable to care for himself or those around him. The ego at this point is not functioning adequately to interpret reality and attend to basic needs of the person.

Students are taught that the main nursing care is to support the patient's weakened ego functions. This includes providing a sense of security and dependent gratifications by remaining with the patient and listening. Questions requiring thought and reasoning should not be asked. Support and direction are provided by using concise, short commands such as "sit here," "eat this," "stand here," "put this shoe on now," thus relieving the patient from making decisions he is unable to make at this point. The basic psychiatric nursing principle this care is based on is "when immediate needs are met (such as security, dependency), more mature needs can arise and be met."

As more community hospital wings are opened, more acutely ill patients who have severe to panic anxiety problems will be seen. The nurse who works in a psychiatric setting needs to be familiar with beginning symptoms of severe anxiety and the effect of her calm, confident manner in handling this problem.

Training in Community Psychiatry in a State Psychiatric Hospital

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N. C. Department of Mental Health

At first inspection state psychiatric hospitals seem inappropriate settings for programs of training in community psychiatry. It takes considerable stretch of the imagination to understand how one can include the community dimension in state hospital residency training programs, inasmuch as these same hospitals have for so long been isolated, socially segregated, monolithic structures walled off from the community both literally and figuratively.

It is true that in recent years there has been a break in the walls which have so long isolated state hospital and community; we have seen a somewhat uneasy integration of hospital with community and a somewhat self-conscious involvement of community in the hospital's programs. It is also true that hospitals have had a rapidly increasing number of admissions of seriously ill patients who have been treated more and more successfully and returned to their homes after an unprecedented short hospitalization. This has helped alter the image of the hospital in the community. It is also true that during this same period our knowledge of the importance of sociodynamic factors in mental illness became much more refined and sophisticated; patients in the hospital taught us that the roots of some mental illness lay in the community, and if we were to understand and treat these patients effectively we had to extend our understanding of their functioning as members of a family and of a larger community. This has called for an ever increasing number of psychiatrists to work in the community and learn to participate with groups, with schools, with health and welfare agencies, and in mental health clinics. Community emphasis is growing in our state psychiatric hospitals; the concept of community psychiatry has stirred the imaginations of psychiatrists including those in state psychiatric hospitals. Yet we have very few psychiatrists, even in mental health clinics, who function in anywhere near the comprehensive fashion we now envision and expect of community psychiatrists.

Where are we to find psychiatrists who are qualified by training and experience to move comfortably and effectively

into this new dimension? Neither university nor state hospital programs has been of much help here. Many psychiatrists move out into the community, either in private practice or in clinics, only to isolate themselves from other physicians, community institutions and agencies. How much of this isolation can be traced to their training as currently given in state hospitals and universities? Our problems of personnel shortage are thus compounded. Not only are we short of trained psychiatrists, but those trained in most of our existing programs were short-changed. They lacked training in the very field into which we talk so glibly about moving, namely that of community psychiatry. But does the need for training programs in community psychiatry to meet public demands and interest mean state hospitals should be forced into what may be an inappropriate role?

Is it unrealistic thinking which brought together concepts of state hospitals and training in community psychiatry or is it the "eureka" process of placing two useful, but heretofore unrelated, objects or ideas together for functional purposes or for solving problems? Perhaps state hospitals do offer a natural setting for training in the principles and practices of community mental health and psychiatry; perhaps state hospitals with training programs should aggressively take leadership in developing strong community-oriented programs.

If this be so, our present programs of residency training demand the closest scrutiny and overhauling. Certainly an overhauling will be necessary if we are to include the current emphasis on community mental health centers, on continuity of patient care, on coordination, and on comprehensive programs including primary, secondary, and tertiary prevention.

When we look closely at the tenor of most current training programs, state hospital or university, we see that they consist of relatively unconnected multiple rotations; emphasis is placed on the individual doctor-patient relationship which is proper, but management of groups, for example, is largely ignored, or not significantly or explicitly emphasized; there is an almost total lack of coordination between the individual, his family and his community; and there is a tendency to work more intensively only with the less sick patients of the middle and upper socio-economic classes. Emphasis has been on prolonged, intensive, individual therapy and little attention has been given to exploring new ways for the psychiatrist to

work constructively with large numbers of very sick patients in or out of the hospital.

Very often state hospital training programs have followed the pattern of university styled programs. This has ignored the fact that the state hospital, with its diversity, its heterogeneous make-up, its large numbers of very sick patients from the middle or lower classes, has some unique contributions of its own to make in training psychiatrists.

In spite of its previous isolated status, I believe the state hospital offers as natural a locale for training in community psychiatry as any other training setting. Perhaps I can defend this in part by describing a training program with a community dimension in a state hospital.

Out of very practical needs the North Carolina Department of Mental Health set out to add, if it could, community psychiatry training to a residency program in a state hospital. We hypothesized that by focusing our training on a working community, both intra and extramurally, residents could be taught all the various essentials of psychiatry in a manner which would also teach them to function comfortably, effectively, and, hopefully, imaginatively in any setting.

Within the framework of a three year residency training program in psychiatry already functioning at Dorothea Dix Hospital in Raleigh, we set out to develop a program to train psychiatrists in the concepts, principles and practices of treatment, prevention, consultation and education for the individual, the family, the group and the community as a whole. A basic aim was to provide all the essentials of a sound psychiatric program within the accepted three year term of the residency, as well as to provide training in community psychiatry. This, I know, is a large order and is contrary to those who advise community training following the basic three years.

Procedure

The most logical procedure for implementing these broad aims appeared to be the creation of an administrative unit commonly referred to as the "unit system or plan" within Dorothea Dix Hospital and incorporating the residency training function into this unit. This hospital has 2500 beds, serves over 1,000,000 mostly rural population and has 22 residents currently in training. The hospital unit consisted of a building of approximately 70 beds. For the extramural segment, or the

geographic area of the program, we chose Johnston County; its county seat and largest town was located 30 miles from the hospital. Johnston County has approximately 65,000 people of whom 78% are white and 22% non-white. During any one year approximately 230 patients were admitted to the state hospital from the county.

Industry in the county was heavily weighted toward low paying, low skill, seasonal type jobs employing mainly women. Overpopulated farms worsened the picture. In the ten years following 1950 there was a net out-migration from Johnston County of nearly 13,000 persons, a solid indication of the poor economic situation. Nearly 3,000 people were on public assistance rolls. The only mental health program available in the county was a part-time mental health clinic staffed one day a week by a consulting psychiatrist who made no attempt to work with any community programs, agencies or institutions. There were 37 medical doctors in the county, 122 general duty nurses and 6 public health nurses. Among the indicators of social disorganization was Johnston County's suicide rate which was almost twice the rate for the state as a whole, with the highest rates being among elderly white men in rural areas. Figures on military rejections and infant mortality placed the county at about the state average but with the highest rates observed for rural non-white residents. The crime rate for white males in the county was at the state average but for non-white males it was significantly above the state rate. The annual rate for juvenile delinquency was about half that of the state as a whole.

This was the physical framework, then, which we chose for carrying out a training project in community psychiatry.

All patients who were already in the hospital from Johnston County were transferred to the building which had been set aside for the unit. Following that, all patients from the extramural county and only patients from that county were admitted to this intramural unit. This included all types of patients, except mentally sick prisoners, who by law were assigned to a maximum security unit. Admission and discharge from this training unit were flexible, allowing for day, night or weekend care if necessary. Furthermore, patients from Johnston County who came into the building were not moved to any other building or treatment ward, but remained in this same building until their discharge back to the county.

Patients were admitted without any selective criteria such as age, race, color, or psychiatric diagnosis. Instead, they were admitted on the basis of need for hospitalization.

In the beginning we placed a third year resident in charge of the unit, with responsibility for its operation, including both intramural and extramural aspects. A first year resident worked in the unit. Both received considerable supervision which was most important.

The chief resident received a total of 10 hours supervision each week at either the county or the hospital unit. This was more than we customarily gave third year residents but out of his and our anxiety, was deemed appropriate. Supervision was in the area of clinical as well as administrative practice, including individual psychotherapy and group work. In the county unit supervision was provided both by staff from the hospital and by a local clinic director who was added a short time after the experiment got underway. This was a different man from the one we mentioned above as doing consultation. The residents spent three half days a week in the county and the remaining time at the inpatient unit.

In the county itself a screening program began, using the mental health clinic in the county's largest town as a base of operations. Here all potential admissions to the inpatient unit were referred for screening before any disposition was made, whether admission to the hospital unit or further planning for community care. I might add that in North Carolina, as in many states, the hospital has little control over its judicial admissions so this screening procedure represented a departure from the usual way of operating. In addition to screening and early treatment, it was the responsibility of the residents to provide for aftercare of patients and to furnish psychiatric consultation to both professionals and agencies in the county.

I implied in the beginning that we took an empirical, pragmatic approach to the development of this project. We had no preconceived ideas concerning the specific ways in which the residents were to attempt to fulfill the aims of the program. The residents were given considerable freedom to implement aims in accordance with their own experience and felt need. We continued to be glad but not entirely surprised at the effective and constructive response residents made to this challenge and responsibility.

We observed the residents going through a series of phases in considering and developing this role as community psychiatrists. Although their previous training had included both outpatient and inpatient work, these were still, strictly speaking, intramural. In the hospital as well-trained, conscientious physicians, they felt responsible for the patient's treatment program from the time the patient entered the hospital until he was discharged. However, concern for the patient pre and post hospital was largely academic.

In the "hospital-community" training unit the residents, being the same conscientious physicians, again felt responsible for the total care of the patient but this time care extended into the community and the concern was more than academic. The first feeling was of omnipotence: "I can do everything for my patients—screening, treatment, aftercare, everything. I'm trained to do these things and I can do them faster and better than anyone else in the community." This was not entirely unrealistic in the community where they worked.

Soon, however, the residents experienced considerable frustration and anxiety for which they needed a good deal of support and supervision. When they began to realize that this was too much for them the question arose, "Who can I find to help fulfill my responsibility to these patients?"

At this point they began to examine the community's resources, its other helping professionals to see where they could find allies who could help in the tremendous job of providing continuity of care for patients.

It was natural first to turn to the physicians of the county in whom the residents eventually found perhaps their strongest allies. This relationship began when the residents started to return a good many patients to the referring general physicians for management. The residents called the patient's physician or sometimes visited him in his office, consulted with him about the patient and assured the doctor of continued psychiatric consultation and cooperation if desired. This type of interaction between the residents and the county physicians took place increasingly in the screening process as well as in the aftercare phase. The following case was an example. It was perhaps a simpleminded example but it did give some idea of the level of initial exchange.

A general physician phoned the resident at the clinic to refer a 52 year old woman whom he described as delusional. He said she was schizophrenic and a candidate for hospitalization. The general physician described the patient's overt symptoms, the predominant ones being hand wringing, crying, much pacing up and down the floor, and delusions of having no stomach and a heart which had turned to stone. The resident asked how depressed was the patient; the referring physician's response was that he did not know. He left the phone to ask the patient directly if she felt depressed. It quickly became obvious that she was indeed deeply depressed and told the doctor she wished she could die. When he communicated this to the resident, the latter speculated that this might be agitated depression, rather than schizophrenia, and expressed a more encouraging prognosis although recommending hospitalization. The referring physician admitted he had learned something and asked for more information about depressive reactions.

It was just in such exchanges, repeated many times, that the residents' relationship with the physicians in the county grew into one of mutual respect and cooperation. The residents thereby learned to understand the problems of the general practitioner in the management of psychiatric cases and the physicians learned from residents some of the techniques of psychiatric interviewing, diagnosis, and treatment. The Johnston County program eventually was accepted enthusiastically by most of the county's private physicians. Initial resistance on their part toward managing the aftercare of discharged patients diminished. In the few cases where the physician would not follow a patient, the residents took over the management. The physicians in the county increasingly called for consultation on hospitalized patients and somewhat unexpectedly and spontaneously expressed an interest in developing a psychiatric unit in the local general hospital.

The need for additional aftercare services for the indigent and those without family doctors soon became apparent. Again, out of their own need for allies, the residents developed another channel of communication and eventual cooperation with a helping group. They turned to the county public health department, holding discussions with the health director and his staff around the whole problem of aftercare. As a result, the six public health nurses in the county began to play an important part in following some patients who were discharged from the hospital. The psychiatric residents consulted on a regular basis with the county public health nurses. This consultation took place in person, by phone, or sometimes the nurse brought the patient to the clinic.

One of the unexpected developments in operating the Johnston County Unit was the large number of alcoholic admissions. Alcoholics accounted for more than ⅓ of all admissions. Faced with this tremendous proportion of alcoholic patients, many of them readmissions, the residents began to explore the community for aftercare resources which might help to break the cycle of hospitalization. They looked for a group of Alcoholics Anonymous, but found the local A.A. group had been defunct for several years. The regional representative of Alcoholics Anonymous was contacted and informed of the need for an A.A. group in the county. He arranged for an organizational meeting to be held in which active members of A.A. from the surrounding area held a sample meeting and invited local candidates to form their own group. The meeting was preceded by a virtual deluge of newspaper publicity on both the editorial and news pages of the county newspaper. Out of the meeting, a nucleus A.A. group was formed and it continued to grow, sparked by frequent referrals from the resident psychiatrists.

In addition, the sheer force of numbers started the residents to work with groups of alcoholics both in the hospital and following their discharge from the hospital unit. Group work with spouses is expected to follow.

Another existing community resource which was developed was that of vocational rehabilitation. Vocational rehabilitation counsellors were contacted by the residents to help in evaluating and placing the patients in work training programs, either as a follow-up to treatment or as a part of a planned program of community care. The community's interest in a rehabilitation house was sparked; when this is added it will bring another dimension to community care.

The county's suicide rate—alarmingly high among older white males—stimulated us to speculate about the impact of an intensive educational program, blanketing the county with materials. Would this have any effect on the problem of suicide, as well as on a number of other problems of high rate in the county? Of course, we did not know the answers. But we wished to experiment with an intensive educational campaign and evaluate the results. The important aspect, germane to this discussion, was the residents' involvement in public education programs as a demonstration of still another type of community program.

We recognized the need for education in another sense. If the community mental health program was to be successful, the people of the county needed to be informed about it and take pride in and support it. The residents soon learned that programs of treatment and prevention, no matter how well founded, must be understood and supported by the people. Requests for educational programs came from a number of groups in Johnston County. The residents were first brought into the planning of these programs and then eventually took the active role in the education process itself. In this way, they not only shared a broad knowledge of mental health and illness with the people, but they also established and reinforced the position as *community psychiatrist.*

As the oncoming tide of patients showed no sign of slackening, and as they deepened the sociodynamic insights in their experience, the residents recognized the necessity for trying to prevent some of the psychiatric illness which they found in the community. Again, out of need, the residents became interested in preventive psychiatry perhaps for the first time. They turned naturally again to the community and asked, "Which are the key groups that I can work with in prevention?" One obvious answer was the schools which seem a logical first line of attack in the early detection of emotional problems and referral of those problems to psychiatric help.

But contacts with the schools brought forth a multitude of problems besides early emotional illness. Our residents came face to face with the problems of mental retardation and realized that the retarded too must be included in a program of community psychiatry. The clinic must participate in the screening and referral of retardates just as it did for the mentally ill and the alcoholic. What resources existed in the community for the mentally retarded? Were there special education classes? Were there sheltered workshops? Was there a rehabilitation house? What facilities should be developed to fill the gaps?

And so it was that the residents, in attempting to meet the pressing day-to-day needs of their practice, began to open doors to the community and to set up lines of cooperation and communication with community professionals and agencies which they never knew existed and for which they never before saw the slightest necessity.

The same sort of process occurred in the operation of the

inpatient unit. In terms of patient makeup, this unit was no different from other wards except that it focused on the community dimension. The residents ran a polyglot ward. They attempted to make it a therapeutic ward in its concern for the individual patient and his needs.

Student nurses were also assigned; there was one registered nurse, a full-time social worker and a complement of psychiatric aides.

There were 60-65 patients on the ward when the unit was first opened; 20 of them had been in the hospital more than 2 years, and some as many as 25 years. The residents were forced to look at these chronic patients in a different light; they could no longer transfer them to another doctor's back ward for continued treatment. What could they do? In some instances they had to recognize that indefinite hospitalization was the best we had to offer now but this brought increasing concern and interest about prolonged hospital stay.

In other instances, the chronic patient led the residents and social worker to explore the possibility of foster homes. When the unit was first started, e.g., it was apparent that 8 of the 20 long term patients on the ward could be placed in foster homes, and 4 additional ones could eventually be so placed. But as the residents explored the resources of the county, no foster homes were found. This caused the residents and the social worker to open a new line of communication—with the county welfare department. With this department they considered the possibility of opening several foster homes to meet the need. The local mental health association, ministers and hospital volunteers in the county joined to help with the search for such homes.

The social worker and the residents sought to develop a volunteer group in Johnston County. This effort was enthusiastically received and an active volunteer group began work. Among other things they supplied funds for aftercare drugs and funds to meet the need for emergency medical care for foster home patients; those qualified volunteered to teach illiterate patients in the hospital to read; volunteers visited the ward frequently, made drapes and assisted in the decoration of the building and furnished plants for the solarium.

Visitors to the ward often remarked on the "family quality" of the place; patients who had previously been hospitalized in other parts of the hospital commented favorably on this

"new" kind of atmosphere. Many patients were observed helping to care for other patients.

A number of ministers in the county came regularly to the hospital to visit patients. They were routinely offered an opportunity to meet with the residents and hospital chaplains to discuss some of their problems in dealing with mental illness encountered in their pastoral duties.

This program even in a relatively short period of operation added some new and, to us, exciting dimensions to residency training. First, the residents were faced with the concept and practice of continuity of care in a way they had not known before. This was in sharp contrast to working with the patient solely within the confines of the hospital or outpatient clinic. Under the unit system of training, residents were never really free of the responsibility for the patient and this included screening, hospitalization, aftercare and rehabilitation. But while this responsibility was tough on the residents and raised anxiety, it proved to be the touchstone for developing community resources to provide for some of the patients' needs which the residents found they as individuals could never fulfill; this was a difficult but forceful way to learn something about coordination of care—its great difficulties, pitfalls and advantages.

Our system, experimental though it was, added the community dimension to the residents' training. They were forced to see and understand patients as members of the wider community, persons with family, social, and agency relationships. The residents were stimulated to try to understand the patient in that dimension and to assist other community caretakers in understanding the patient and help provide for his needs in the community setting. We hoped, however, that we were not training just community psychiatrists but generalists who worked comfortably in hospitals in communities, academic settings, private practice, etc.

This was an educational process for the residents themselves, and I might add, often a very threatening and discouraging one. It was a confrontation process and they needed a great deal of support and encouragement from the supervising psychiatrists. This was also an educational process for community professionals and agencies, general practitioners, welfare caseworkers, public health nurses, ministers and others. It was an educational process for the admin-

istrative hierarchy of the hospital as well, and again a threatening one. We recognized that changing the residents' training was going to mean eventually altering considerably the training and function of every person working in the hospital.

As you see, we took a frankly pragmatic approach to the development of a training program in community psychiatry. We did not begin with conceptual outlines of sociology, group processes, community work, etc. By our method we obviously approached training in community psychiatry backwards; we did not start with the community, but with the hospital and worked back into the community. This, however, I think, assured us a sound clinical basis and orientation in the community and always allowed the clinician to work in and from his area of competency. However, we were forced to reexamine our traditional fields of competency such as inpatient ward programs. Charity begins at home and to us community psychiatry began in the hospital. We have had the temerity to say: Our state hospitals will not only continue but can also become the hub of modern psychiatric treatment. We will, in the future, have the gall to ask any new director of community programs first to work three months in such a unit program to gain the coordinated "hospital-community" experience.

Our theoretical framework eventually evolved from evaluation and observation of the program itself. Seminars gradually precipitated from this working program and therefore had direct relevance to it. We believed that seminars on hospital organization and disorganization, agency consultation, public education programs and principles of preventive psychiatry had meaning related to experience. However, I was impressed with the great amount of reading residents were stimulated to do. A great deal of self learning went on in the program—perhaps more than in the usual or traditional program.

We have considered the outrageous possibility of utilizing this program for all three years of residency training. We believe it has all the elements of a sound clinical training program in general psychiatry. The addition this year of a child psychiatrist will give us an element heretofore lacking in supervision. We think first year residents might begin in a well developed unit such as the Johnston County program and by their third year be prepared to penetrate an uncharted

community—and gain the experience of working out all the necessary lines of communication needed to establish a community mental health program de novo.

Our program in North Carolina is based on our own climate, our own ecology. Needless to say, the specifics of this would not work in New York, Massachusetts or Vermont. I hope what I have conveyed is a belief that considerable flexibility can be attained in a training program—a program not patterned on anyone else's, or on the university, or on a traditional basis—but on its own culture, and yet a program that can have all the elements of sound training plus *experimentation.*

In our residency training program we attempted to add this dimension of experimentation just as in any laboratory; in this instance the laboratory was "the community," including the hospital. We hoped above all else to promote and keep alive in residents an attitude of experimentation as they approached the many complex problems in comprehensive psychiatry, including its community aspect.

Forensic Psychiatry: Criminal Responsibility

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It is the intention of this paper to cover some of the concepts and philosophy of criminal responsibility and then the so-called tests of criminal responsibility.

In considering the philosophy of criminal responsibility it becomes evident that not only are there divergent opinions between psychiatrists and lawyers, but also there are widely divergent opinions given by psychiatrists. Noyes and Kolb in *Modern Clinical Psychiatry* state "Psychiatry seeks to ascertain the forces that result in behavioral deviations and how they may be re-directed to greater intrapersonal serenity and more constructive and socialized purposes. The law deals largely with social control of behavior." They go on in discussing criminal responsibility to say, "According to the concept held by law, the mind is dominated by reason and full will, and behavior results from a consciously determined intent. - - - Psychiatry, on the other hand, assumes that mental processes are controlled by both conscious and unconscious factors, the latter playing a very important part. - - -"

Dr. John R. Cavanagh published a paper in *The Catholic Lawyer* (Vol. 4, No. 4, Autumn 1958) entitled, "The Responsibility of the Mentally Ill for Criminal Offenses." Dr. Cavanagh makes several points clear in his discussion of the need to improve communication between psychiatry and the law. In his discussion he reveals numerous semantic problems. He gives, for example, the words insanity and psychosis, saying that some present day psychiatrists are reluctant or even refuse to use the term insanity saying it is a legal term. Dr. Cavanagh points out that its definition is given in Hensie's *Psychiatric Dictionary* published in 1940; Hensie defines fifty-two types of insanity.

Dr. Cavanagh quotes Albert Einstein in regard to criminal responsibility from Einstein's paper *What I Believe,* "I do not believe we can have freedom at all in the philosophic sense, for we act not only under external compulsion but also by inner necessity." Schopenhauer's saying "A man can surely do what he wills, but he cannot determine what he wills," impressed itself upon Einstein in his youth and he says,

"always consoled me when I have witnessed or suffered life's hardships. This conception is a perpetual breeder of tolerance, for it does not allow us to take ourselves too seriously; it makes rather for a sense of humor."

In this writer's opinion this is the cause of all of the differences of opinions between psychiatrists and lawyers, also between psychiatrists. It reverts to the old philosophical question, does man have "freedom of will" or is he controlled by deterministic forces completely and always beyond his control? Will this question ever be completely answered? This is uncertain, but the writer will give his point of view and method of attempting to work with this problem in evaluating alleged criminal patients for the courts of North Carolina. (At the Dorothea Dix Hospital approximately one hundred and sixty-five to two hundred persons charged with crimes are evaluated each year.)

First, if we examine the concept of determinism and take it to an extreme, one must conclude that a man is the product of his environment, genetics, etc., and is not responsible for his behavior. It would follow that the responsibility for any violation of the law would be placed on society as a whole and not on the individual. Therefore, if determinism is taken to this extent one would conclude that there is no need for laws if the individual is not to be deemed responsible for his acts. One must admit that the conclusion sounds ridiculous; however, the writer heard psychiatrists who have testified that any person who committed murder or attempted suicide was psychotic and should not be held responsible for his acts.

Sheldon Glueck in his Isaac Ray Lectures (April 1962, delivered at the School of Law and the School of Medicine of Tulane University) expressed the problem clearly, "The jurist who claims that the Criminal Law is built on the reality of intentional and controllable wrongdoing, holds the offender both morally blameworthy and legally culpable because he claims the offender could have avoided doing the prohibited act. The jurist thereby expresses a face of the truth based on his interpretation of experience. The psychoanalyst who insists that human behavior is largely conditioned by subconscious forces and by crucial experiences of early dependent childhood concludes that the attitude toward human failing should be sympathetic and therapeutic rather than condemnatory and punitive. Thereby, he too is expressing an aspect of

truth. And the geneticist who reminds us realistically of a feature of the problem which many behavioral and social scientists tend to ignore—that there are such tough, and as yet unyielding, substances as genes and protoplasm—is likewise expressing an aspect of truth."

Can these apparently contradictory truths be reasonably accommodated? Glueck goes on to propose degrees of "freedom of the will." He says, "It may help us to see this if we imagine a simple chart which shows the freedom/determinism proportions of a feeble-minded person, an extreme psychotic, an average "sociopathic" or psychopathic personality, a genius who (unlike some geniuses) also happens to be a well integrated personality, and the fictional "average," reasonable man resorted to often as a standard measuring rod by the law."

	Free-choosing	Predetermined
Feeble-minded	10%	90%
Psychotic	10-40%	60-90%
Sociopathic	30-45%	55-70%
Genius	70-90%	10-30%
"Average"	50-65%	35-50%

Glueck continues, "Of course, all such speculation, intended to make more concrete and vivid a complex ethico-psychological concept, is a gross oversimplification both in the estimates of the quantum of free choice area and in the assessment of the genic and environmentally conditioned participants in setting the limits of free-choosing and free-acting capacity. The rough picture I have sketched also suggests a too mechanical relationship of the free and controlled elements in the total situation. It may nevertheless be of some help in visualizing this abstract and speculative problem."

In examining Glueck's concept of degrees of freedom/determinism it would appear that it does not conform to the legal concepts. Law measures its standards on an average man and takes little or no consideration of incapacities, unless the weakness is so marked as to fall into well known exceptions, such as idiocy or madness. The law assumes that all men are as able as every other to behave as they command. This general standard does not solve the problem as to whether a particular defendant deviates sufficiently because of mental disease or defect from this standard to be deemed not responsible and therefore not guilty. Also, in Glueck's formula, the

"average" man has at best 65% free-choosing, therefore one might conclude that responsibility and free-choosing are not equal thus making the problem of determination of responsibility more difficult and not always directly related to 100% free-choosing.

The writer's working concept to determine responsibility is a compromise in this freedom/determinism variations. In spite of these variations man has the ability to intervene in this process and to make a choice to modify or change the end result of his behavior. Glueck seems to agree with this when he states, "I think it is reasonable to assume that the recognition of biological and sociocultured causality in human behavior does not exclude altogether a realistic concept of capacity for choice which different persons possess in varying degree. True, the law is compelled to deal with a standard of the typical or average man. But, despite the presence of mechanism in some aspects of personality, it does not necessarily follow that individual embodiments of this mortal man do not have some modicum of capacity for consciously and purposefully intervening in the causal chain to guide their behavior to conform to legal prohibitions and sanctions. However, much of this creative capacity may vary in individual instances."

If a series of events are begun by this unconscious it does not mean that the individual cannot alter or prevent the intended end result. For is this not the intent of psychotherapy and psychoanalysis? It is unusual that an individual in therapy alters his conflict. In most instances the individual learns to live with his impulses and drives. The individual has a capacity to stop at the onset or at various stages in the sequence of events to alter it. Even in physical science the inflexible cause-and-effect determinism has been rejected. Anyone who clings to a rigid determinism in the belief that the "demands of science" require this, is confusing the cause-and-effect linkage.

This point of view fits in with the ordinary and preferred concepts of mankind. If we analyze the basis of moral responsibility we should conclude that it arises from the general feeling and belief, founded on life's experiences, that a person possessed of the usual human faculties to an apparently usual degree is capable of acting and therefore is expected to act according to an accepted, socially required standard of morality.

If we discard the concept of responsibility of the individual for his acts and place the blame on society, anarchy and chaos would follow. This freedom-of-will/determinism concept, and the belief that a person should be held responsible for only that amount of blameworthiness that each one possesses, creates a dilemma. The law nor psychiatry has a ready solution of this dilemma, and it is being passed back and forth, and neither has devised any reliable or workable measuring rod to enable even an expert to gauge the amount of free will possessed by the defendant. With our present law a person is either responsible or not responsible. There is little or no provision for partial responsibility. In present day thinking many reject the concept of "let the punishment fit the crime" and are proponents of the concept of rehabilitation with correction of the defect within the individual. Others continue to ask why should society not be protected in some manner? Also, what assurance do we have, that after a given sentence of X-number of years, that the defect will be corrected? In our present state of knowledge can science give any degree of assurance in answering these questions? The law seems to assume if an individual is responsible for a criminal act, and he is placed in prison for a certain number of years, the wrong will be corrected and the person will not commit any further violation of the law.

There apparently are several unanswered questions in the matter of criminal responsibility. First, how can it be measured with some degree of accuracy? Second, if an individual is partially responsible, what should be the disposition? Also, even though the crime was committed during a dissociative state, how will he handle his guilt if his own code of ethics tells him he should be punished? Sheldon Glueck stated, "How very necessary is more thorough and revealing psychological and sociological knowledge to any constructive efforts to redeem those offenders whose character can effectively be modified and to keep in safe and lawful incarceration those who continue to present a social hazard!"

It is the opinion of the writer that the solution may lie in the concept of an undeterminate sentence in the case of any major violation of the Law. During the confinement the person should receive adequate treatment depending on his motivation accompanied by rehabilitation and vocational training if indicated. Release would require recommendation by a board of lawyers, psychiatrists, psychologists and sociologists. Even

then errors would be made in releasing a person too early. This is not a new concept, but we must realize it is in opposition to our present constitutional law and legal opinions. This is a large and expensive order but we must admit our present crime and punishment is extremely expensive and has produced little in results. This is not to say that our prison systems have not shown progress but we have done little or nothing to reduce the crime rate through punishment.

In discussing the so-called sanity tests (or tests of insanity) it is clear that these are not tests but are court rulings. In 1843, following the trial of Daniel M'Naghten in which he was acquitted of the murder of Edward Drummond, a discussion took place in the House of Lords that proposed five questions to the fifteen Judges of England regarding the law of insanity. The answers of the judges have been reduced to two rules: (1) To establish a defense on the ground of insanity it must be clearly proved that at the time of committing the act, the party accused was laboring under such a defect of reason from disease of the mind as not to know the nature and quality of the act he was doing, or if he did know it he did not know what he was doing was wrong." (2) "Where a person labors under partial delusions only, and is not in other respect insane, and commits an offense in consequence thereof, he must be considered in the same situation as if the facts with respect to which the delusion were real." Expressed another way; to establish a defense on the ground of insanity, it must be proved that at the time of commiting the act, the party accused was laboring under such defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing, or if he did know it he did not know he was doing what was wrong. This is commonly known as the "right or wrong test."

The M'Naghten rules have been criticized in many ways for a number of years. It was said the rules are not in keeping with our present knowledge in psychiatry and behavior. Historically, in the limited states the next change in law regarding criminal responsibility was the opinion of the Supreme Court of New Hampshire in 1869. The court ruled that an accused person is not criminally responsible if his unlawful act was the result of mental disease or defect."

In 1954 the Court of Appeals for the District of Columbia Circuit handed down the now famous Durham Decision. It was in substance the same as the New Hampshire Rule of

1869. It says as follows: "We find that as an exclusive criterion the right and wrong test is inadequate in that (a) it does not take sufficient account of psychic realities and scientific knowledge, and (b) it is based upon one symptom and so cannot validly be applied to all circumstances. We find that the irresistible impulse test is also inadequate in that it gives no recognition to mental illness characterized by brooding and reflection and so relegates acts caused by such illness to the application of the inadequate right-wrong test. We conclude that a broader test should be adopted.—It is simply that an accused is not criminally responsible if his unlawful act was the product of mental disease or defect."

Now, let us consider an example under the M'Naghten Rule. If a mentally ill person were to believe a man is about to take his life and kills him, as he supposes "in self-defense," he would be exempt from punishment. On the other hand, if a person delusively believes that the victim had inflicted a serious injury to his character and fortune—something that would not excuse a sane individual—a deluded person killing him in revenge would not be excusable. In the latter case under the Durham Rule the accused would not be responsible.

The Durham Rule has been praised as a great advance in law regarding criminal responsibility. It is more in accord with present knowledge in psychiatry and human behavior. In regard to this ruling, the psychiatric testimony which was given in the lower court was strictly adhering to that permitted under the M'Naghten Rule and no consideration was given to the fact that Durham was mentally ill. Before adverse criticism is hurled at the psychiatrist it should be remembered that some courts have been very strict in the testimony they will permit a psychiatrist to make; that is to say no evidence beyond whether or not the person knows the difference between right and wrong is allowed. The psychiatrist if often not permitted to explain the basis of his opinion. Frequently he is only permitted to answer "yes" or "no" to a question phrased by the prosecution or the defense counsel. A second point in regard to the Durham Rule is related to the terms "mental illness" or "mental defect." Should it include a disorder listed in the *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association? It seems certain there would be much disagreement if all of these disorders were included, as this

could include as much as forty to fifty per cent of the population and for mental deficiency alone would be about fifteen per cent.

In an attempt to reach some solution to this problem the State of Vermont legislature adopted the following law in 1957 as a test of insanity as a defense in criminal cases: "1. A person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he lacks adequate capacity either to appreciate the criminality of his conduct or to conform his conduct to the requirements of law. 2. The terms 'mental disease' or 'defect' do not include an abnormality manifested by repeated criminal or otherwise anti-social conduct. The terms 'mental diseases' or 'defect' shall include congenital and traumatic mental conditions as well as disease."

It is the writer's desire that a similar statute may be passed by the North Carolina General Assembly in 1965 since the state has no legislative law regarding insanity as a defense. There is under what the legal profession calls "Case Law" a ruling accepting the M'Naghten Rule. Some judges adhere to the strict interpretation of this rule, however, there is no set pattern. In the writer's experience some are very flexible and allow testimony regarding degrees of mental illness. One judge ruled that any person suffering from a mental illness as defined for hospital admission was not responsible for his criminal action.

In summary, can the matter of freedom of the will as opposed to determinism be settled? How can we measure responsibility? Should everyone with an oedipal conflict not be responsible? There are many other questions with partial or no answers. It is my hope that this paper will stimulate some thought on the matter.

Convulsive Activity as a Biological Adaptive Mechanism

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INTRODUCTION

In the complex organization of an industrial society it is difficult to conceive of the grand mal seizure's having any adaptive value. The epileptic is disqualified by nature of his malady from many industrial occupations (1, p. 214) and in many cases is alienated from participation in the social aspects of the culture (2, pp. 17-19, 21-23). The danger inherent in the nature of the convulsion: the disturbing personality trait corollaries of epilepsy (3, 4) and the sometimes associated mental deficiency (5, p. 623; 6, p. 448) often lead to the ultimate institutionalization of the epileptic. This cultural disability resulting from epilepsy, however, is not universal. In some primitive societies the epileptic finds himself in a much more favorable situation, the grand mal convulsion often being an essential attribute for the attainment of the "higher offices" of the primitive religion. With our cultural bias against epilepsy it is difficult to orient to the concept of the convulsive activity's serving a beneficial physiological function.

In this paper the author presents data which leads to the postulate that this bizarre expression of nature, e.g. the grand mal convulsion, has a meaningful protective function in the survival of the species.

Part I. GENERAL OBSERVATIONS ON EPILEPSY AND CONVULSIVE PHENOMENA. THE CONVULSION AS A SPECIFIC RESPONSE TO NON-SPECIFIC STRESS.

The diverse pathological etiology of the grand mal convulsion would lead one to postulate that the epileptic seizure is a specific response of the central nervous system to non-specific stress. The diverse pathology of which epilepsy may be symptomatic includes morbid anatomical changes in the central nervous system; vascular (7, 8); inflammatory (9-14); space occupying lesions (15-19) and trauma (20-23). Besides structural changes in the central nervous system, symptomatic seizures result from humoral changes whether produced by endogenous or exogenous mechanisms. Disturbances in endocrine

function (24-27); electrolyte imbalance (27); disorder of water balance (28-29) and disturbance in acid-base balance (30) have all been incriminated as etiological in the production of seizures. Exogenous epileptogenic factors are generally the clinical or addictive use of analeptic drugs (31-33) or the withdrawal from anti-convulsant or sedative drugs (34-36). Some of the tranquilizers have the apparently paradoxical property of being epileptogenic (37-39). The concept of nonspecificity of stress in producing seizures is admirably illustrated by the fact that the central nervous system appears to be exquisitely sensitive to the ecologically paradoxical stresses of oxygen lack and also oxygen excess (40-43).

The Ubiquitous Nature of Epilepsy

The grand mal convulsion is a latent physiological mechanism universal in its distribution in homo sapiens, higher animals and birds (44). Epilepsy has been noted in diverse geographical areas, knowing no cultural or ethnic barriers (45). Hirsch (46), while considering the total incidence of neurological conditions, described epilepsy in the following terms: "There is no other so widely spread in time and space and no other has such pronounced ubiquitous character as epilepsy." Davenport (45) felt, however, that there was variation in ethnic incidence of epilepsy, being less frequent in Negro populations.

The Convulsive Therapies

The universal susceptibility of the individual to the grand mal convulsion is a self-evident fact to the psychiatrist. Since the introduction of convulsive therapy by Meduna (47) this has remained an enduring therapeutic agent in the treatment of depression and other mental illnesses. Various methods have been used to induce therapeutic grand mal seizures including the use of intra-muscular camphor (47), intravenous metrazol (48-50), and a combination of an intravenous analeptic with intermittent photic stimulation (51-53). A recent innovation in the pharmaceutical production of convulsions has been the use of Indoklon (hexafluorodiethylether), a substance with the paradoxical properties of both producing anesthesia and being epileptogenic (54-56). Since Cerletti and Bini's induction of a grand mal convulsion by electrical stimulation (57), pharmaceutical convulsive therapy has been

replaced almost entirely by electrical convulsive therapy modified with a muscle relaxant (58-59). (Most of the physical dangers earlier associated with shock treatment have been eradicated by modification.) Convulsive therapy not only demonstrates the universal nature of the latent convulsive phenomenon, but also illustrates how the therapist's ingenuity has exploited the non-specific etiology of the grand mal convulsion to find more reliable and safer means of inducing convulsions.

From the literature it would appear that the therapeutic mode of action of shock treatment is intimately associated with the production of a grand mal seizure. Sub-convulsive doses of electrical stimulation have been reported as having little beneficial therapeutic effect (51, 60-62) and may make the patient refractory to later grand mal convulsive therapy (61).

Roth's hypothesis postulated that convulsive therapy acted as an adaptive mechanism allowing the central nervous system to re-adjust physiologically to a more efficient pattern of biological function thus tending to normalize deviant thought, emotional or behavioral patterns which were secondary to disturbed physiological function (63). This general normalizing effect would account for the many paradoxes in the therapeutic activity of E. C. T. where diametrically opposite behavioral patterns, e.g. retarded depression and hypomanic hyperkinesis or schizophrenic withdrawal and schizophrenic excitement, respond favorably to this therapy (64, 65, p. 193; 66, 67, 68, p. 55-81). Perhaps the best illustration of the behavioral normalizing effect of convulsive therapy is the beneficial response obtained in many confusional states of specific etiology (69-71).

The Distribution of "Epileptogenicity"

If one accepts the grand mal convulsion as a physiological behavioral pattern latent in all individuals, one might expect the individual susceptibility to vary from person to person with distribution being on a normal curve. Various studies on "neurologically normal" populations using metrazol activation of the electroencephalogram tend to segment the population into various classes. A large percentage of the populations show no abnormal electrical activity under this stress. When the abnormal reactivity is graded in severity it is found that the greater the intensity of the abnormal electrical activity, the smaller the percentage of reactors, thus producing the "lower tail" of the normal curve distribution (72-75).

There is less experimental data referring to the "upper tail" of the normal curve distribution. One study, however, reported that when 1000 mg. metrazol was administered to 51 Air Force volunteers, 43 of these candidates had spike wave potentials on their EEGs (76). This would denote that a smaller percentage of this population were resistant to the epileptogenic properties of relatively large doses of metrazol.

A normal curve distribution of "epileptogenicity" would explain "essential" epilepsy as being statistically defined, i.e. those individuals who occupied the extreme of the lower tail of the distribution. The "essential" epileptic would have an exquisite sensitivity to normally subliminal stimuli or to unusual epileptic precipitants (77-79). This statistical concept of "epileptogenicity" might have an ultimate physiological explanation in the varying sensitivity of a possible "central regulatory apparatus to maintain homeostasis" as postulated by Davies (80). Theoretically, the individual's placement in the normal curve distribution would be defined by genetic factors. The heredity of essential epilepsy and cerebral dysrhythmias has been well documented (81-88).

Another interesting observation is that the incidental development of symptomatic convulsions following brain trauma cannot be explained completely on a morbid-anatomical basis (89-90). To develop symptomatic seizures it probably requires a constitutional factor of "epileptic proneness."

Recapitulation

This paper has presented the concepts: (a) that the grand mal convulsion is a latent physiological mechanism, universal in its distribution; (b) there is evidence to suggest that the sensitivity to epileptogenic stress is a variable which forms a normal curve distribution in the population; (c) material from clinical psychiatry suggests that the grand mal convulsion by biological adjustment of function may have a normalizing effect on disorders of thought, emotion and behavior.

Part II. THE FUNDAMENTAL MEANING OF THE GRAND MAL CONVULSION

In recent years considerable attention has been paid to the synthesis of isolated physiological phenomena into a comprehensive theoretical framework. An example of this is General Adaptation Syndrome of Selye (91). On reviewing the literature it would appear that little attention has been given

to a fundamental biological interpretation of epileptic phenomena.

Martin Roth (63) elaborated on a concept, first postulated by Cerletti (92), that the grand mal convulsion might be a homeostatic mechanism with a biological function. He presented both experimental and literary data to strengthen his postulate. Poetzl (93) also stresses the homeostatic function of epilepsy describing the epileptic brain phenomena as having a "pathological regulatory function" representing fundamentally a "vegetative crisis."

An attempt will now be made to elucidate the biological function of convulsive seizures, a function that may be as critical in the survival of the species as any other singular biological phenomenon.

Relationship of Age to Epileptogenicity

It would appear that there is a definite inverse relationship between age and sensitivity to convulsive disorder. The high incidence of convulsions and the instability of EEGs in infancy and childhood have been well documented (12, 40, 95-102). Peterman (95) reported a large series of cases of convulsive disorder which showed a decreasing incidence of onset of convulsions from infancy onwards (7% of convulsions beginning in the first neonatal month and 68% of convulsive disorders beginning before the 36th month). In congenital heart disease Tyler and Clark (40) reported decreasing frequency of convulsions with increase in age. Lennox (102) describes this age distribution of sensitivity to convulsions as "the peculiar sensitivity of the young." If one were to extrapolate this "age-sensitivity curve" into the intra-uterine life of the fetus, one would expect an even greater sensitivity to convulsion-producing noxious stimuli. The high incidence of seizures in premature infants would appear to confirm this latter theory (103).

Grossman (104) in a study of cerebral electrical ontogeny in kittens found a greater tendency for the production of spike potentials in the EEGs of younger animals as compared to adult cats. (On sensory stimulation of a fore-paw, high potential spike and wave complexes were recorded in the contralateral sensory cortex in animals sensitized with pentylene tetrazol.) He presented the theoretical concept that an explanation of some convulsive phenomena might be the electrical regression to an earlier ontogenic phase as a result of damage

to the more vulnerable later-developing areas of the central nervous system.

Studies of Fetal Behavior

As a result of observations on fetal behavior, Coghill (105) postulated that, ontogenically, mass movement was the most primitive fetal behavior. With maturation of the central nervous system these movements become more refined and coordinated. However, Windle (106) postulates the converse theory, namely, that the earliest fetal movements are of a discrete, refined nature, probably reflex in origin. The mass movements previously noted by Coghill (105) are described as stress reactions of the organism to asphyxiation. Experimental data (107-110) both in the animal and human fetus tend to confirm Windle's theory. According to Windle and Becker (188) progressive anoxemia to the fetus leads to a definite sequence of events: (a) increased irritability of reflex mechanisms, (b) suppression of reflex activity, (c) mass movements of fetal musculature. The more profund the asphyxia the more tonic and sustained are the mass muscular movements. In some of these experiments these mass movements are described as being of a convulsive nature. Barcroft (111) also illustrated that a relatively mature sheep fetus would awaken instantaneously from inertia to convulsive activity on occlusion of the umbilical vessels.

Recapitulation

The second part of this paper has drawn attention to the greater susceptibility of the ontogenically more primitive central nervous system to convulsive activity as compared to the mature central nervous system. Experimental data from fetal studies would suggest that convulsive muscular activity is the fetal behavioral reaction to the stress of anoxemia.

Part III. CONCLUSIONS

The weird cry, the tonic spasm, the myoclonic movements and the cyanosis of the grand mal convulsion make such a grotesque series of events that they would appear to defy any rational explanation. However, accepting the concept of the grand mal convulsion's being a latent physiological pattern of behavior and having traced the individual susceptibility to convulsions to the early stages of maturation, the author

would like to present the concept of convulsive activity being a fetal adaptive mechanism.

Hypothesis I. Fetal adaptation to the intra-uterine environment.

If one considers a living organism of fetal shape suspended in a fluid medium in a closed sac, the mechanics of a grand mal seizure become meaningful. The tonic contraction in extension would stretch the uterine wall and subsequent paroxysmal myoclonic movements would then "shake" the fetus into a more accommodating position. The seizure phenomena would thus be a "built-in" protective mechanism giving the fetus an active means of protest if its existence were being endangered.

The peculiar sensitivity of the central nervous system to oxygen deprivation (106-111) and the unique lifeline which the fetus has would appear to demand a fetal mechanism of defense against the hazard of anoxemia. The role of anoxia (112-118) is a well-defined cause of fetal mortality. Perhaps without the convulsion many more fetuses would succumb as a result of local mechanics interfering with the supply of life-sustaining oxygen.

Hypothesis II. Determination of presentation and position of the fetus.

The vertex presentation is the normal presentation of the fetus (119, p. 198). Two major factors define this normality, namely: (a) The fetus presents in this manner in an overwhelmingly larger number of cases, and, (b) this presentation expedites delivery in the most efficient manner, mechanically. The preponderance of vertex presentations is generally explained in mechanical terms which treat the fetus as an inert passenger with all dynamic procedures being determined by the contractility of the maternal uterus. DeLee and Greenhill (119, p. 198) state that the preponderance of head presentations follow the law of accommodation of Pajot, "Where an ovoid body lies free in an ovoid container, the two long axes tend to become parallel, which is especially true if the container contracts as does the uterus. The child, as it lies folded together is void: the uterus, at the end of pregnancy likewise. The uterus is not a flaccid sac, but has some tonus and keeps its tonus, and further it contracts frequently

(the contractions of pregnancy)." If the fetus were to get into "physiological difficulties," presumably through anoxia during its dynamic interaction with the uterus, the extensor tonic spasm of the seizure would further help to align the long axis of the fetus with the long axis of the uterus. The ensuing myoclonic movements would return the fetus to the flexed fetal attitude.

An active mechanism of extension would appear to be even more useful if not essential in multiple pregnancies, e.g., twin pregnancy where two living organisms have to be maintained with their long axes parallel to the long axis of the uterus. The incidence of vertical lies in both fetuses at term is 90% as quoted by DeLee and Greenhill (119, p. 482) (both in cephalic position, 47.4%; head and breech presentation, 34.2%; both breech presentation, 8.4%). The adaptive nature of this principle would be invaluable in higher animals where multiple pregnancy is the rule.

Hypothesis III. The adaptive value of a convulsive mechanism during delivery.

The mechanical value of a built-in mechanism of fetal extension can be appreciated in several situations during delivery. (a) The presenting part, e.g., the vertex, would become a dynamic thrusting instrument in the dilation of the cervix. (b) Extension of the fetal vertebrae would result in the breech of the fetus being thrust against the contracting fundus. (c) The fetus would become a rigid organism more easily expelled through the constricting areas of the birth canal.

The concept of the fetus aiding expulsion as a result of pressure of the breech on the contracting uterine fundus has already been described and is known as the principle of fetus axis pressure. However, extension of fetal length was interpreted as being secondary to increased hydraulic pressure in the amniotic fluid compressing the fetus from side to side (120).

Radiographic evidence would suggest that in the third stage of labor, in fact, there is extension of the fetal vertebral column coincidental with uterine contractions (121).

The question arises—Does the fetus suffer from sufficient anoxemia during a powerful uterine contraction of the third, and perhaps second, stage of labor to induce tonic convulsive

contractions? On account of the complexity of the physiological processes involved in this process, the author was unable to obtain a direct answer to this question from the literature. However, there is little doubt that any uterine contraction of sufficient intensity to cause slowing of the fetal heart [fetal anoxemia producing vagal inhibition (122)] will also cause fetal convulsive activity with the resulting tonic extensor movements aiding expulsion of the fetus. Thus a rhythmic dynamic interaction is established between the fetus and mother.

The use of large dosages of analgesics and anesthetics in the mother during labor are well-defined causes of infant brain damage and fetal mortality (123-126). This pathology cannot all be ascribed to asphyxia neonatorum as has been pointed out by Schreiber (118). Could it not be that these medications by their anti-convulsive activity deprive the fetus of an essential protective adaptive mechanism?

Having established a theoretical "raison d'être" of convulsive movements as a fetal protective mechanism, one could then postulate that neonatal convulsions represent a regression of central nervous functioning to a more primitive level of ontogenic activity.

A comprehensive bibliography was compiled for this article and is available on request.

Current Research Abstracts

HANS H. STRUPP, MARTIN S. WALLACH, RONALD E. FOX AND KENNETH J. LESSLER.

(Department of Psychiatry, University of North Carolina)

An Investigation of Outpatient Psychotherapy.

The present investigation is designed to provide data that might aid in better procedures for selecting patients who can profit from the kind of psychotherapy offered by psychiatric outpatient clinics; attempts to encourage experimentation with more efficient and economical treatment techniques; and provide better utilization of available therapists by achieving an optimum "match" between patient and therapist in terms of probable treatment outcomes.

The procedure consists of (1) systematic study of extensive self-reports by former patients who have been treated in a psychiatric outpatient clinic; (2) detailed analyses of relevant data available from the clinic charts of these patients; and (3) intensive exploration of the statistical relationship between patients' retrospective reports, therapists' evaluations, objective psychological test data, and a variety of socio-environmental variables which may be related to therapeutic outcomes.

Data have been collected by means of a comprehensive questionnaire from former patients who had at least 25 hours of individual psychotherapy with a psychiatric resident. Of 244 former patients to whom questionnaires were mailed, 129 returned completed forms; 59 patients who presumably received the questionnaire failed to respond after a follow-up request had been addressed to them; 17 persons refused to participate in the survey; and the remainder of the questionnaires was undeliverable for various reasons. The analysis of the data is currently in progress.

This study takes its point of departure from a recently completed investigation by H. H. Strupp, M. S. Wallach, and M. Wogan. "Psychotherapy Experience in Retrospect: Questionnaire Survey of Former Patients and Their Therapists." Psychol. Monogr., 1964, 78, No. 11 (Whole No. 588).

ERIC SCHOPLER, Ph.D.
N. C. Memorial Hospital, Child Psychology Unit

Learning-teaching Interaction With Psychotic Children.

I. For the past four years the Division of Child Psychiatry has been engaged in a demonstration project of group psychotherapy with psychotic children and their parents. The first group of children has advanced to the level where they are able to attend public schools in their community.

Our major research effort with this group is focused on the children's learning problems and how these can be compensated and diminished. We are studying the children's ego deficits and functions in the context of the relationships they have developed with their teacher-therapists

and peers. Within these relationships the children express their individual themes and communication peculiarities. As these are identified we look for methods of using their available channels of communication for broadening the range of their interaction with the outside world.

The children's developmental fluctuations are studied for specific deviations in receptor modalities. Some children still make excessive use of their near receptor systems of touch and taste, others show preference within auditory and visual distance receptor systems. All of our children show varying degree of difficulty in integrating sensory information for appropriate understanding of reality. We are hoping to delineate methods for increasing the child's integrative capacities vis his available channels of communication.

II. Study of Sensory Processes in Mental Retardation.

This is an interdisciplinary study with the School of Education geared to developing special teaching programs, utilizing the preferred sense modalities in retarded children.

Our part includes the development of techniques for measuring the child's differential use of sense modalities. Speed of discrimination learning in the visual, auditory, kinesthetic and tactual modalities are studied, and this will be correlated with his inter sensory processes in other learning situations. One of the long range goals in this research is the assembly of tests to establish individual sensory profiles.

III. Family Diagnosis

We are developing some methods for diagnosing the entire family groups from which a child is referred for outpatient treatment. We expect to identify the difference in diagnostic interpretations available from individual assessment compared with information available from a family diagnosis.

SLATER E. NEWMAN
(N. C. State University at Raleigh)

Paired-Associate Learning

We are studying how learning occurs on the paired-associate task (e.g., how a subject learns the *name* for an object, a word or a concept). We are interested in identifying the processes involved in this kind of learning and in understanding how these processes operate. Our approach has been to conduct laboratory experiments aimed at testing predictions derivable from a theoretical model for paired-associate learning. This has resulted in concern with problems like the following:

1. Direction of association—does learning the pair, A-B, result in equivalent learning of the pair, B-A?
2. Serial presentation—does presenting items in the same serial order on all trials facilitate their learning and subsequent retention?
3. Isolation—does emphasizing (i.e. isolating) an item in a list affect learning of the nonemphasized items?
4. Test rate—does a decrease in test rate during training facilitate learning, performance, or both?
5. Clustering—does clustered presentation of items from the same category facilitate the learning and subsequent recall of these items?

Usually visual stimuli have been used. Recently we have also been using tactual stimuli so that we can (1) observe what the (blindfolded) subject does in exploring the stimulus and (2) identify the cues he uses in discriminating it from other stimuli.

Subjects have been college students and nurses-in-training. Work has been supported by the North Carolina State Faculty Research and Professional Development Fund and by the Office of Naval Research.

Eva Somjen, Ph.D., Visiting Associate Professor
(University of North Carolina Department of Psychiatry,
Division of Child Psychiatry)

Research Into Clinical Neuropsychological Diagnostic Methods.

Between psychiatry and psychology there is the no-man's-land of the child with minimal organic affliction where superimposed neurotic or psychotic defenses mask the phenomenon.

Available diagnostic tools are quite inadequate in this respect and the experience and sensitivity of the clinical psychologist are the only guides to the diagnosis. Quantification and accuracy of prediction are needed. Scores on subtests and judgments based on interpretive tests are expected to yield a finer mesh than presently available. Cross-validation on homogenous material will further refine predictability from the test results. In this study, several groups of patients are being tested with wide spectrum of diagnostic tools. A double-blind experimental design is employed and the investigator has no direct contact with the members of the homogenous groups who are mixed randomly with controls from birth registers. Probands are seen in a setting not reminiscent of the original cause of affliction.

The expectation is to find in the intercorrelation of tests and subtests a valid structure diagnostic of

1. Marginal Brain Pathology, which eludes diagnosis by standard neurological methods
2. Some specificity as to etiology
3. It is planned to draw developmental curves of the sequelae of early childhood organic afflictions permitting prediction and planning for education and
4. Trace organically damaged children between psychoneurotic and psychotic (autistic) in order to modify management and therapy.

So far, pilot studies have been made of post-meningitis children and are currently done on children and adults above I.Q. 80 without gross neurological abnormality or very obviously deviant EEG, but with history or symptoms suspect of brain injury, e.g. defects of higher symbolic functioning, distortive space orientation, or very unequal I.Q. subtests.

In addition, a large number of post-meningitis cases have been collected. Minimal C.P. and premature birth are the next categories to be investigated. Another 10, possibly more, categories are expected to fall into this area.

In preparation for a research manual, investigator sees personally neurologically screened hospital cases.

R. E. LUBOW
(Department of Psychology and Zoology, N. C. State)

Latent-Inhibition

Latent inhibition describes the effect of nonreinforced pre-exposure to the to-be-conditional stimulus. The research program in this area has been concerned with a description of the latent inhibition phenomenon as it is affected by such variables as number of pre-exposures, delay between pre-exposure and training, and such subject variables as age, species, and type of conditioned and unconditioned response. To date the studies have used sheep, goats and rabbits and have involved the leg withdrawal reflex and the pinna reflex to shock. The results have significance for theories of learning with particular reference to such questions as the relative importance of response processes and stimulus processes.

The work has been supported by the National Institutes of Health.

R. E. LUBOW
(Department of Psychology and Zoology, N. C. State)

Form Discrimination

A variety of studies at our laboratory have been concerned with visual form discrimination and perception.

In one series of experiments the aim has been to elucidate the mechanism for the development of form perception and in particular the role of eye movement. A method for visual image stabilization has been developed for the goat, but has not proved to be satisfactory.

Other studies have been concerned with the utilization of a "spontaneous" pattern discrimination technique where exploratory behavior is used as the index of a discrimination. The interest has been in assessing the technique and determining the relative weights of various sensory modalities.

The third area of interest in regard to form discrimination is the study of the invariant stimulus properties utilized by organisms exhibiting form constancy. As in the previous studies animal subjects have been used, primarily the rat and pigeon.

These studies are supported by the National Institutes of Health, the Systems Engineering Group of the USAF, and a North Carolina State Faculty Development Grant.

DALE C. MORTER
(Department of Psychiatry, North Carolina Memorial Hospital)

The Ecological Veracity of Children's Reports of Parental Attitudes

Available evidence suggests that children's report of parental attitudes may be of considerable value in investigations of both normal and abnormal personality development. An instrument has been developed to obtain children's reports of parental attitudes from relatively young

children. Questions have been selected in an attempt to evaluate parental attitudes along two major dimensions, Love-Hostility and Autonomy-Control. This instrument will be administered to approximately 400 school children in grades four through six. The ecological veracity (i.e., the extent to which the report corresponds to objective reality) of children's reports will be investigated by determining the degree to which siblings agree in their descriptions of their parents.

GEORGE S. WELSH, Ph.D.
(Department of Psychology, University of North Carolina)

Research at the Governor's School of North Carolina

For the summers of 1963 and 1964 an eight weeks' residential school for gifted adolescents has been held in Winston-Salem on the campus of Salem College. Support from the Carnegie Corporation and business leaders of Winston-Salem ensures operation through 1965, and it is hoped that the state will then take the school over on a permanent basis. Approximately 400 rising juniors and seniors from all of the school districts are selected each summer to participate in classes classified under the Academic Division (English, French, mathematics, natural science, and social science) or the Arts Division (painting, drama, dance, vocal music. and instrumental music). Students in the Academic Division are selected on the basis of outstanding scholastic records in a given area, a high IQ, and recommendations by school officials. In the Arts Division selection is made on the basis of demonstrated talent in a special area by means of auditions and actual performance rather than by paper records. Data gathered on all of the students includes standard tests of personality, creativity, intelligence, interests, values, self-concept, and attitudes. Some especially devised instruments have been used as well as ratings and rankings by teachers. These data are now being analyzed and will be collated with biographical information. It is hoped that follow-up studies can be carried out so that long-term findings can be added to the current results.

BOOK REVIEWS

BLISS, EUGENE L., editor 1962. *Roots of behavior; genetics, instinct, and socialization in animal behavior.* (symposium) Harper & Bros. (Hoeber Medical Book), New York. xi + 339 pp., figs. & tables. $16.00

The American Psychiatric Association often sponsors a symposium at the annual meeting of the American Association for the Advancement of Science and the book *Roots of Behavior* is a product of one such symposium. Edited by a psychiatrist and authored by 31 animal behavior researchers, the book (according to its editor, E. L. Bliss) ". . . hopefully offers some guide to current research and suggests that complex behavioral problems can be delimited and clarified in animals." Dr. Bliss also tells us that the symposium was organized on the assumption that ". . . the study of man's nature and its aberrations lags for the lack of suitable tools to investigate them." A meeting devoted to animal behavior was arranged ". . . not because the ultimate answers to man's behavior were evident in contemporary work in this field, but because the area offered *new techniques* to study the problems of behavior."

The book might be of interest and value to ecologists for much the same reasons that it might be useful to psychiatrists: the 23 contributions offer a fair sample of how psychologists and zoologists interested in animal behavior go about their work, both from the technical and conceptual points of view, and many of the problems under consideration are of immediate relevance to ecological questions. (Before calling your favorite bookseller, please be advised that the price of the volume is $16.00. The large number of illustrations are of good quality, and the print is quite readable, but the 339-page book is not as luxuriously put together as the price might imply.)

Each author reports mainly about his or her own experimental work, though there are also brief general reviews of the behavior of genetics literature (by Zoologist W. C. Dilger) and the aggression literature (by Zoologist J. P. Scott), and a fairly comprehensive review of determinants of alcohol consumption in mice (by psychologists Rogers and McClearn).

Most of the individual research is reported in great enough detail so that the non-specialist can get a good idea how the data were collected and what the particular procedures involved (activity wheels, mazes, tests of "emotionality," surro-

gate "mothers" for kittens and infant monkeys, and so on).

Mathematically oriented ecologists might be most interested in psychologist Jan Bruell's application of biometrical genetics to an understanding of the occurrence of certain behavioral tendencies in several inbred mouse populations. Those interested in a genetic analysis of polymorphic behavioral tendencies will find the fruits of such a program of research in the contribution of psychologist Jerry Hirsch, who reports in part on Loise Erlenmeyer-Kimling's analysis of the chromosomes correlated with negative and positive responses to gravity (geotaxis) in flies of the genus *Drosophila.* Rounding out the section dealing with the genetics of behavior, anatomist Robert Goy and his colleague Jacqueline Jakway present some evidence, both from invertebrate and vertebrate studies, which suggest to them that the form or pattern of sexual behavior within a species is relatively fixed, while intraspecific genetic variance contributes largely to variation in the quantitative aspects (frequency, duration, intensity) of sexual behavior.

The bulk of *Roots of Behavior* is devoted to analyses of the events and factors which operate between the establishment of the genome and the appearance (or non-appearance) of species-typical behavior in the adult animal. The events are developmental; the factors are chemical, glandular, stimulative, and experiential.

However, only a portion of the empirical bridge between genetics and the development of behavior is presented in this book, and for that reason there appears to be a disjunction (indeed, there *is* a disjunction) between the six chapters dealing with the genetic analysis of behavior and the dozen or so chapters intended to depict the developmental analysis of behavior. The connecting link which is overlooked is the prenatal study of behavior. Such an extraordinary amount of relatively complex behavior occurs before birth or hatching in all species, including *Homo sapiens,* that the area of "behavioral embryology" can be truly regarded as the taproot of behavior. Neglect of this area is most unfortunate in a book which otherwise concerns itself with the foundations of behavior. Though the analysis of prenatal behavior may be less popular today than it was 30 years ago, it is no less important.

Some of the experiments and notions in *Roots of Behavior* in which ecologists might be most interested and of which

they might be least aware: In a thoughtfully designed set of experiments, Evelyn Shaw observed the sexual behavior of platyfish reared under eight different environmental conditions after hatching. It is most interesting that depriving these fish of visual access to the general surroundings inhibited the appearance of sexual behavior even more than depriving them of intra-specific visual contact. In the same conceptual vein, Daniel S. Lehrman reviews his own work on ring doves, and the work of others on guinea pigs and cats, leading to the conclusion that the effectiveness of hormones associated with sexual and parental behavior is largely determined by the developmental history of the individual. Ethel Tobach and T. C. Schneirla also find that the individual developmental history of mice plays a formative role in one conventional laboratory index of emotional behavior (frequency of defecation). These writers challenge the unity of the concept of "emotionality," and favor the view that disturbed behavior is a situationally specific response rather than an individually generalized pattern prescribed by genotype.

The contributions of a number of authors support the idea of "critical periods" in development, periods wherein the young animal is particularly sensitive or responsive to certain kinds of environmental stimulation, and periods which affect subsequent behavior by what was or was not experienced during them. The critical period concept, formulated in modern times by William James in 1890, extended by Sigmund Freud in the early 1900's, rediscovered by Konrad Lorenz in 1935, and re-awakened by J. P. Scott and M. V. Marston in 1950, finds explicit application in physiology (Seymour Levine), imprinting (E. H. Hess), and social development in birds and mammals (Nicholas E. Collias) in *Roots of Behavior*. In view of the popularity of the critical period notion with their psychiatric audience as well as some of their colleagues, it is a testimony to intrepid scholarship that John L. Fuller and Marcus B. Waller reminded everyone that S. Freud did not believe that *all* neuroses stem from early experience. Fuller and Waller also presented their conception of "schedules of experience" as a way of avoiding some of the difficulties of precisely defining and crucially testing the critical period notion.

With respect to group behavior, Stuart Altmann analyzes aspects of social communication and sexual behavior in free-

living anthropoid primates and C. Ray Carpenter reviews his naturalistic observations of variations in composition and size of groups of howler monkeys living on Barro Colorado Island over the last 30 years. John B. Calhoun describes some odd behavior which arose in his quasi-naturalistic experimental arrangement for studying aggregative behavior in domestic albino rats. Among other curiosities, the sexual behavior of the males became indiscriminate as well as promiscuous, while the females encountered all sorts of physiological reproductive difficulties. Finally, David E. Davis offers some unorthodox but relevant phylogenetic comparisons to human gang behavior.

The main emphasis of *Roots of Behavior* is on the analysis of early postnatal experience in relation to the subsequent manifestation or inhibition of species-typical behavior. It is here that the conceptual dilemma of the science of animal behavior is clearly brought to the fore—our chronic inability to synthesize the findings from the genetics of behavior with those of early experience. The inability is not merely a function of the fact that experimenters who take the genetic route do not systematically manipulate early experience, while experimenters who take the early experience route do not systematically manipulate progenitors. Rather, it also has something to do with our thinking, dominated as it is by an either-or, two-valued logic (heredity-environment, innate-acquired, instinct-learning), and limited by that same logic, regardless of our verbalisms to the contrary.

It is clear that "early experience" participates in the formation of species-typical behavior, and it is equally clear that the developing organism is not a blank slate. Individual workers in animal behavior have not yet synthesized those two propositions.

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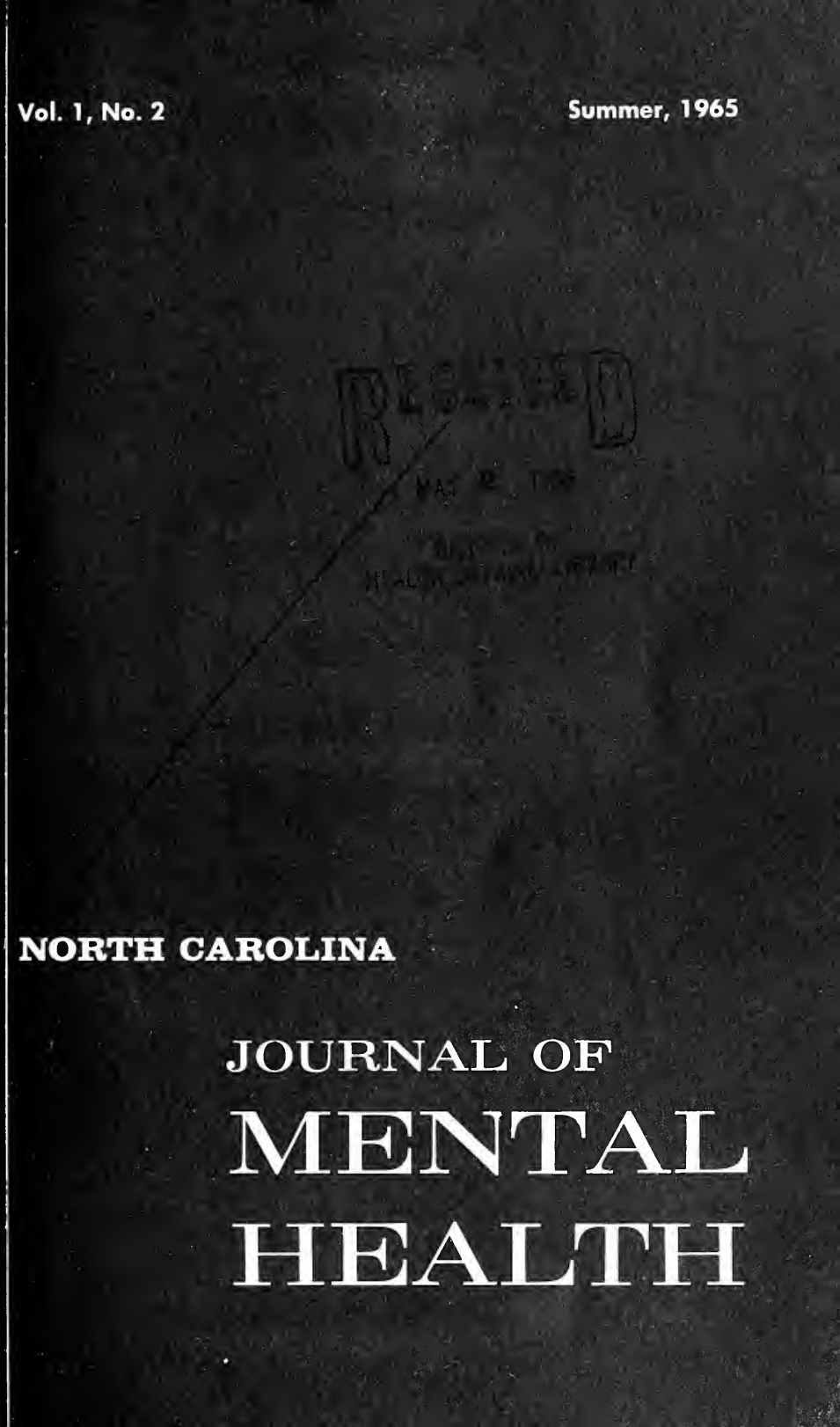

NORTH CAROLINA

JOURNAL OF MENTAL HEALTH

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NORTH CAROLINA JOURNAL OF MENTAL HEALTH
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This journal is intended to be inclusive rather than exclusive and is not meant to be regarded as simply a house organ of the North Carolina State Department of Mental Health.

It is hoped that the journal will reflect the broad-based philosophy of psychiatry current and will draw on areas reflecting the total spectrum of psychiatric and neurologic thought, program and research.

Subscription may be obtained by writing the Editorial Offices, North Carolina Department of Mental Health, P. O. Box 10217, Raleigh, North Carolina.

(Notice to contributors — see inner back cover)

NORTH CAROLINA JOURNAL OF MENTAL HEALTH

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EDITORIAL

Gratifying Response

We have been gratified by the response to the first edition of this journal. It apparently has had, as was our goal, an appeal to a cross section of disciplines involved in mental health work. We hope to continue to publish a journal which will be of broad interest and yet maintain the high caliber in articles submitted and allow for treatment of topics in depth. This is not to say, however, that we will not publish articles of some limited interest, as they are appropriate. In view of the many disciplinary journals, we would expect that specific scientific articles with limited implications would be submitted to them. We are interested in articles which demonstrate new program areas and which reflect efforts to review current and potential models of activity in mental health and psychiatry.

We find ourselves in the midst of general role definition and re-definition, program innovations and evaluations, and trends towards interdisciplinary approaches. We hope the JOURNAL will reflect these.

N. E. Stratas, M.D.

Programming for Prevention

FRANK KIESLER, M.D.

Director, Northland Mental Health Center, Grand Rapids, Minnesota and Clinical Associate Professor of Psychiatry, University of Minnesota School of Medicine

I live in a community which five years ago began to tax itself to buy a mental health program. Convinced by the earnest salesmanship of a public school superintendent, a general medical practitioner and a county welfare director, the taxpayers envisioned a typical psychiatric clinic, and perhaps even a few psychiatric beds, to serve the sixty-eight thousand people living in three rural northern Minnesota counties.

Here was an area, almost the hize and shape of the state of Massachusetts, with no mental health specialists whatsoever. Some parts of the most northern county on the Canadian border were two hundred miles from the nearest private psychiatric help. The state psychiatric hospital serving the region was even farther from this border county. More happily situated was the southernmost of the three counties. Its county seat was only sixty miles from the state hospital. The apparent need was for psychiatric services within more reasonable distances.

In the six years since 1959, the mental health program has not developed in these three counties as originally visualized. There is still no psychiatric clinic, and there are no psychiatric beds in any of the local hospitals. The three professional staff members hired during 1959 and 1960 had other ideas about how the mental health needs of such an area might best be met. With increasing acceptance and implementation of these ideas by key people in these three counties, another pattern of mental health services has evolved.

In 1959, when our three counties appointed a nine-member community mental health board to organize and operate a mental health center, it was assumed by most people that a psychiatric clinic providing direct diagnostic and treatment services would solve the community's most pressing mental health problems. Also, many had very specific goals in mind. Busy doctors wanted to turn the care of certain troublesome patients over to a psychiatrist. School administrators needed the services of a psychologist for IQ determinations. The

juvenile court hoped that psychiatric treatment might answer the question of what to do with youthful offenders. Wives of alcoholics hoped their husbands might be brought under control. PTA program chairmen anticipated lots of speeches to help fill their program schedules. Almost everyone was found to have his own special expectation. Rapidly it became clear that somebody would have to enunciate some overall task definitions so that truly community-serving patterns could be evolved, particularly since tax money was going to pay for what was done. A few people recognized that the community could not afford to have the mental health center become the captive of any one problem group, no matter how needy and deserving.

In any community, in any population, two kinds of health tasks can be defined. One of these is the care of existing and emerging casualties, the clinical task. The other is the task of reducing the numbers of new casualties, the preventive task. Medicine generally has steadily become more proficient in meeting both tasks. Where do we stand in mental health? Probably the best medical analogy is cancer control. With both mental disorder and cancer we have become better at early diagnosis and treatment. In neither field do we as yet have anything akin to primary prevention through immunization.

In our three counties, budget limitations made it clear that within the foreseeable future only three professional staff members could be employed by the mental health center. What, then, were to be the functions of one psychiatrist, one clinical psychologist, and one psychiatric social worker in relation to the mental health problems existing and emerging in a widely and thinly dispersed population of sixty-eight thousand persons? How could the capabilities of these three be put to work for the most people? How could their efforts best be addressed to both clinical and preventive tasks?

When we three arrived in the area, there was one obvious answer. We weren't alone. Although we were the only mental health specialists in the three counties, we were certainly not the only sources of help for mental health problems. It was obvious that before we came, someone had taken some kind of responsibility for helping those with mental health problems. Not every troubled person had been packed off to Duluth or to the Twin Cities or to Moose Lake State Hospital

for specific psychiatric services. Systematic inquiry showed that our three counties had a professional manpower pool of over 300 persons who had been having various kinds and degrees of influence on the mental health of troubled people. These were the doctors, the lawyers, the clergymen, court-services personnel, school administrators and counsellors, the welfare case workers and the public health and school nurses.

Since these firing line professionals knew the community and its mental health problems, we reasoned that we could best concentrate our efforts on learning how they had been doing their jobs so that we could find how we might most effectively join our capabilities with theirs. We began by deciding that it was absolutely essential that none of them be permitted to turn his mental health business over to us. We were convinced that, if the community were to meet its clinical task, firing line professionals would not only have to continue to take responsibility for mental health problems, but they also would have to increase their proficiency in doing so. We concluded that systematic approaches to the preventive task would have to wait until experience with the clinical task had taught all of us much more about the mental health problems and resources in the community. Besides, it was clear that the clinical door was the only one open. We had to use it.

When we explained our ideas about the necessity of keeping the clinical base in the community itself—with the firing line professional, most listened attentively and politely agreed that we had described a most logical approach. There were some scattered anguished howls of protest, and a few denounced us as impractical dreamers who would only waste the taxpayer's money. In fact, a few doctors decided we were the entering wedge of socialized medicine—a fifth column—and concluded that to traffic with us would be unethical and perhaps even dangerous. One doctor almost cost us a substantial chunk of our budget support one year by giving a local merchant, the president of the Taxpayer's Association, the impression that all of the doctors thought the mental health center should be run out of town. It took a public county board hearing to set the record straight, and it was set straight by the testimony of doctors.

Despite our attempts to describe a broader concept of mental health center operation, almost every firing line pro-

fessional went right on trying to use us in the only really familiar way— as a psychiatric clinic. When referrals came, we immediately engaged the referring professionals. We talked with them on the telephone or saw them anywhere or at anytime convenient for them. We asked for information, not only about prospective patients and their families, but also about the realities of professional practice in this area. In all sincerity, because all of us had come to this area as strangers, we literally asked them to be our teachers—to help us become more usefully oriented. When firing line professionals talked about how they had been trying to solve the mental health problems which had come to them, we began to find that their reasons for requesting help from the mental health center tended to fall into either of two general categories.

In one category, help was requested in reaching specific professional decisions. Probate judges wanted help in deciding whether or not psychiatric hospital care really would be appropriate for some of the persons brought to commitment hearings. Doctors wanted help in deciding how to appraise and deal with people who cut their wrists or took overdoses of medication. Doctors also wanted advice about how best to use new psychotropic drugs. Sheriffs needed to decide whether prisoners in jail were showing signs of mental illness or "just acting up." In paraphrase, the most common question was, "Is this to be treated as sickness, or dealt with as a behavior problem?" Generally, most hoped it would turn out to be sickness and, therefore, a problem for the psychiatrist. Most diagnostic errors were in the direction of labeling immature or misbehaving people sick. Only infrequently was mental illness either missed or dismissed. All firing line professionals wanted to know if it was appropriate for them to continue to try to take responsibility for some kinds of problems, or if they should be transferred to the medical health center or to a psychiatric hospital for specialty help.

In the other category, help was requested because some kinds of problems were making firing line professionals uncomfortable. Aside from difficulties caused by certain personal sensitivities or biases, most discomfort appeared to stem from feelings of professional inadequacy. Most often it was stated directly: "I don't know what else to do," or, "I'm too busy to struggle with this kind of problem," or, "This woman is calling

me all the time, and driving me nuts!" or, "I've done these things, but maybe the mental health center can do what is really needed."

As mutual experience in interprofessional consultation grew, and with it, mutual acquaintance and confidence, it more frequently was mutually concluded that firing line professionals were either doing all that could be done or that other suitable ways of solving problems were available at the local level—and that direct intervention by us would accomplish no more. As time went on, we were more often asked to confer about problems than to see patients. More than once at two in the morning the phone rang and there would be a doctor 140 miles away on the Canadian border saying, "I've got a problem, and I want to see what you think of what I'm doing about it." Within three months our waiting list for direct clinical service had permanently disappeared. By the end of 1960, seven of every ten families about whom we were asked to consult were continuing in the care of local professionals without having had direct contact with us. Currently we see less than two of every ten families about whom we consult. We see families ourselves when specific psychiatric opinions are required, or, when evaluation by us will lend needed weight to conclusions or recommendations, and when we can deliver brief therapeutic services not available from other sources in the area.

Some interprofessional clinical consultations are one-shot five minute curbstone sessions. Others require several contacts, sometimes with the inclusion of other local professionals. The doctors have found that many acute crisis reactions can reverse rapidly if handled in the local hospitals on the regular wards. We may give them a hand with some of these, but we have no hospital patients of our own, nor do we write prescriptions. We are on the move too much. We need to keep the local doctor in the driver's seat as far as consistent medical responsibility is concerned. If psychiatric hospital treatment should be required, we often assist in arranging for it elsewhere. We know that if there were a privately practicing general psychiatrist in our area, fewer people would have to go elsewhere for specific psychiatric care. We have been trying to recruit one.

We've done some crude analyses of the costs of the various things we do. When we describe our two kinds of clinical

work (direct service and clinical consultation) in cost terms, we find that seeing families ourselves for direct clinical services costs the mental health center budget ten times as much per family as does consultation with firing line professionals. Our average total cost per family seen by us at the mental health center is $245. Our average total cost per family consulted about and not seen is $25. Analysed another way, we have found that per unit of our professional time, we can influence nine times as many families through clinical consultation as we can through direct clinical service. Since this trend became apparent in 1961, we have progressively increased our consultative assistance to other professionals and decreased our direct service time to what appears to be an irreducible minimum. With only ten percent of our time currently spent in direct clinical contact with patients, we do not consider ourselves to be operating a psychiatric clinic. Our pattern of consultation activities has also shifted from its original totally responsive one to more regularly scheduled visits to doctors' offices, welfare departments, schools, clergymen, and others. For example, with only 39 doctors in the three counties, and those grouped almost entirely into three hospital staff groups in the three county seats, we can literally see most of them regularly.

The fact that more than eight of every ten families about whom we consult are never seen by us does not mean that we have set up family doctors, clergymen, sheriffs, social workers and a host of others in an imitation of psychiatric practice. These people are not interested in stepping into other professional roles than those they already have. Our experience shows that most troubled people in our area obtain no better results with our help than they do with local professional help. One of our working hypotheses is that the earlier that problems of adaptation can be defined by firing line professionals, the better the results that can be obtained from relatively simple straightforward corrective approaches. We have a major research program going to test this and related propositions.

Illustrating what can happen with straightforward approaches is the experience of a general medical practitioner in our area, a big burly Irishman who pitched bush league baseball to help put himself through medical school 15 years ago. Five years ago, when he found he would have to continue

to take care of many patients he had hoped to send to the psychiatrist who was coming to the new mental health center, he grumbled, but agreed that the logic of the mental health center operation demanded that he "do psychiatry" whether he wanted to or not. Throughout these six years he has continued to grumble. He has also worked hard at increasing his proficiency. He has learned a lot about when to listen and when to take action. Besides talking with us about patients, he has several times arranged for me to sit with him in his office or at the hospital while he sees his people, as his guest. (At first he tried to maneuver me into taking over, but I refused, saying, "These are your patients — you are the doctor — I'm your guest!) He has helped to organize some series of formal seminars on diagnostic and therapeutic principles useful to family doctors in our area. He has also become involved with us in community mental health planning. (Parenthetically, I should say that he is not alone in becoming involved in all of these things, other doctors are, too.)

The other day he told me that he now regularly schedules patients who need to talk through some of their problems for the last half hour in the afternoon, and charges them ten dollars for it. He said that he had put off doing this for a long time because he feared people would protest about the larger fee. When he finally went ahead, he was delighted to find that his patients simply put their ten dollar bills on the desk as they left. He said, "You know, after fifty-three patients in an afternoon, it's kind of nice to take your time with the last one, and I feel like it's worth something." Then he added, "I saw one last night, though, that I just couldn't charge."

He described having been called out into the country to a miserable shack to see a woman who was acutely reacting to the death of one of her twelve children. She stood in one corner, mute and unresponsive, seemingly catatonic. He was able to walk her over to a chair and put her in a sitting position, but there she remained, immobile and staring into space. He began to talk to her about losing her child. When he said, "You have to realize she's dead," it was like pulling a trigger, and suddenly the woman burst forth with screaming that seemed completely out of control as it went on and on. He waited, and when finally she stopped and lapsed into sobbing, she was completely accessible to comforting by her husband and children, and he left them that way clinging

to each other in full mutual expression of their grief. When I remarked that there was more than professional satisfaction in his voice as he told the story, he turned to me and said, "But I still don't like to do psychiatry!" My answer was, "That sounded more like the practice of medicine to me."

I want to describe now how large numbers of professional and lay persons throughout our three counties have been collaborating in educational activities, community planning, and research, all with the objective of finding approaches to the task of prevention. This is where our real hope lies. The adaptive casualties we have, and will continue to have, must be cared for with increasing ingenuity, and continued devotion. But we cannot afford to delude ourselves into thinking that better patient care will be a sufficient answer for the mental health problems of communities. Until we can find how to bring about actual reduction in the numbers of adaptive casualties of all kinds in populations, we will have only begun to scratch the surface of our mental health problems.

In our section of north Minnesota, we have committed ourselves to the long-range task of assisting a three-county community of sixty-eight thousand persons to mobilize and deploy its mental health-influencing resources so as to improve the effectiveness of all kinds of measures, both clinical and administrative, for identifying, sorting, and handling existing adaptive casualties and for developing preventive programs—all with the objective of finding out if doing this will produce significant reduction in the prevalence and incidence of casualty behavior in the total population. Our general hypothesis is that this can be accomplished.

Toward the end of the first year, in the course of clinical interaction with all varieties of professionals, we more deliberately began to turn attention, in terms related to their own areas of concern and competence, to the necessity of utilizing more than clinical approaches if the mental health picture in the whole community were to change. We began actively to sell our convictions that appropriate mental health programs must include more than concern with the already sick and handicapped, more than work with individuals or even individual families—but, also, organized efforts based on public health principles and carried out in the community at large as community functions.

A natural outgrowth and extension of interprofessional clinical consultation has been organized education for professionals. As professionals were helped with clinical problems they began to ask for more systematic presentations aimed at enabling them to become more proficient in diagnostic and treatment techniques. From the beginning, both in clinical consultation sessions and in accepting referrals, our staff has emphasized the desirability of focusing upon the whole family rather than upon single individuals. When we were asked for more formal systematic presentations, we continued with the family focus. In this context we have been able to foster a transition from disorder-centered evaluation and assistance toward an interest in health maintenance and promotion.

In consultation regarding families where the apparent initial reason for professional attention was disorder in one member, it has been possible to stimulate interest in formulations which include, not only planning for correction or management of disorder, but also for protection and enhancement of the mental health of others in the family group. These are concepts well known in both medicine and social work, but we have found they need repeated restatement and reclarification in the mental health context. Further, so that total professional effect could be exerted over a broadened base, it was possible to foster a shift in orientation toward the value of employing only bolstering or holding actions for those with unalterable handicaps while using sharply focused brief techniques to assist those most capable of change.

Reciprocally dependent upon each other are the remaining two sectors of our public health functions. These are community planning and research. From successful development of clinical consultation, there was a gradual transition to administrative and program consultation with school and welfare administrators who were concerned about how their policies and programs were affecting the functioning of their organizations and the groups of people for whom they had responsibility. Shortly, these people began to ask us to join with them in appraising the meaning of the masses of data accumulating in their files and in determining from it what directions they might take in various aspects of their own program planning.

From the beginning we had been building into the structure of the mental health center the machinery for consistent

quality control research on our own activities. From the beginning we had also hoped to become able to facilitate the development of an apparatus for continuous measurement of changes in the adaptive health of the whole population of our area in relation to changes in the deployment and utilization of all mental health influencing resources. As we became active in program consultation, key administrators very quickly began to talk with us about their needs for systematic program appraisal methods, and very soon it became clear that we were engaged in the preliminary stages of community-wide epidemiologic research program development. Since 1961, we have been fortunate in having become able to set up an entirely separate research organization to design and put into action a comprehensive continuous community epidemiologic study in our area.

If an epidemiologic study is to have practical value, appropriate items must be counted. For example, an attempt to use the base rate for schizophrenic reactions as a criterion in a given population immediately comes-a-cropper on the problem of what to count because of serious disagreements about the proper criteria for diagnosis of schizophrenic reactions. On searching for less equivocal and more useful items to count in establishing base lines for which to measure change, it is possible to conclude that certain events, symptomatic in nature to be sure, but reasonably readily countable, can be used. These are bio-psychosocial events to which the community attaches significance, generally because people in the community think it would be better to have fewer of these events. A few of these are marriage failures, school dropouts, juvenile court hearings, mental hospital admissions, and accidents of various kinds. If we examine marriage failures, for example, we immediately see many kinds, and several possible causal sequences are suggested. In our area we have become particularly concerned about one particular kind of marriage failure because of its apparently high frequency in the group in which it occurs. We have become concerned, also, because it has provided the opportunity for demonstrating to the community one way in which preventive programs may be put into action.

Early in the history of the mental health center, our attention was taken by a rapidly growing roster of marriage failures among couples not yet out of their teens, or at most,

only in their early twenties. In addition, these marriages all had one fact in common in that they had occurred because of pregnancy and, that by the time of failure, there had been born, not just one child, but usually two, three, or even four children. At the time of failure, the marriage partners were bitter and discouraged and felt cheated. They were completely fed up with marriage and children. Our concern about these marriages arose, not just because many pairs of teen-agers had made a mistake in trying marriage and parenthood before they were ready, but also because there were regularly at least two children involved. Similar concern about this problem has been voiced in many parts of this country in recent years.

Our research organization is now obtaining accurate local data on the annual incidence of such marriages, the incidence of failure, what happens to these families after failure, and what may be the differences between those that fail and those that do not. Meanwhile, however, in order to have a preliminary basis for deciding what might be done about these families, we early obtained estimates of the frequency of failure from those sources we considered best able to provide such information. These were the family doctors. We chose family doctors because they diagnose pregnancy, deliver babies, and supply medical care to young families, and because they are generally in at both the beginning and at the end of such marriages. The doctors' estimates of failure rates for such marriages in our area ranged between fifty and one hundred percent, with estimates averaging at about eighty percent.

When the whole sequence leading to failure of these marriages is inspected for points at which preventive activity might become effective, it becomes redundantly obvious that the ideal solution should ultimately come from more adequate preparation of children for handling adolescent relationships so that there would be fewer pregnancies propelling teen-agers into premature marriage. However, on looking for something with the possibility of faster pay-off, we concluded that there was one point at which the sequence of pregnancy, marriage, child-bearing, and marriage failure might most readily be interrupted. Because almost invariably these marriages had been arranged by parents to solve the problem posed by pregnancy, and because practically all of these

marriages had been performed by clergymen, it occurred to us, as it has to others, that clergymen might hold the key. If clergymen could become convinced that the long range results for everyone concerned would be better if marriage did not occur, they would be in an ideal position to counsel pregnant teenagers and their parents toward another kind of solution.

By not performing marriages carrying such apparently high failure risk rates, clergymen could become key people in setting into motion a train of preventive events. Instead of allowing marriage to be used as the only alternative, clergymen could offer help to teenagers and their parents in working out plans that might have more of a chance of correcting than of compounding the mistake. If not permitted to marry, teenagers might be helped to use opportunities to finish growing up and preparing for mature marriage. If suitable for adoption, the children to be born of these pregnancies could have the opportunity to start life in stable families. Further, without marriage, second, third, and sometimes fourth children would not be born while their parents were least prepared.

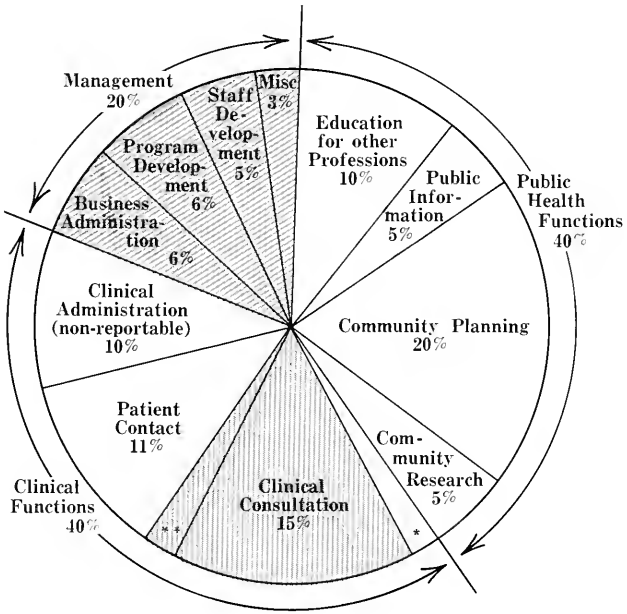
This, then, is one of the preventive formulations professional persons and the general public in our area have been slowly translating into changes in community attitudes and practices in the hope of reducing the incidence of disorder arising from this particular source. Taking the lead have been one of the county mental health associations and some of the clergymen. We have served as resource persons. In one of our larger towns we found that the Roman Catholic priest had independently come to the same conclusions and had already announced to his congregation that he would perform no more pregnancy-propelled teenage marriages. His reason was that he expected those he married to stay married, and these people were not remaining married.

Two mental health association-sponsored workshops on "Finding Better Solutions for Problems Resulting from Teenage Pregnancy and Marriage" for clergymen, school administrators, school counsellors, school nurses, doctors, welfare caseworkers, attorneys, justices of the peace, and others, were well attended and were thoroughly reported in the local newspapers. Civic organizations, parent groups, and youth groups have asked for information. The general reaction has

been one of relief that someone has finally talked about this in public. But, more than that, it has mobilized a ground swell of serious interest in family and community responsibility for better preparation of all children for eventual marriage and parenthood. Thus far, those who are asking the most questions appear to be the most healthy members of the community. We hope their interest will provide a portal for study of adaptively successful families. We hope to become able to describe the epidemiology of mental health in this area, as well as that of mental disorder.

Each year more of our professional time and effort is allocated to assisting in community programming of various kinds. We are convinced that the avenue to reduction in prevalence and incidence of casualty behavior is not professional service to individuals but changes in community attitudes and practices.

PREDICTED AVERAGE DISTRIBUTION OF PROFESSIONAL TIME



* Clinical Research —2%
** Clinical Consultation (Center Patients)—2%

The pie-graph shows that 40% of professional time is allocated to clinical functions, and that 15% is assigned to what we call clinical consultation. We have designated as clinical consultation those sessions aimed at assisting other professional persons to handle clinical problems themselves in their own areas of practice. Only 11% of professional time has been reserved for direct diagnostic or therapeutic activities. Another 10% is spent in clinical administration which includes such patient-directed activities as telephone calls, preparation for appointments, working on clinical records, clinical research data collection, handling correspondence, and many other necessary clinical activities carried out in the absence of patients.

From the beginning, in handling our clinical functions, several procedural rules have been followed:

1. No one will be seen by us for direct clinical services unless a legitimately responsible professional person or agency in his local area has first evaluated the problem and has then talked with us. Pre-screening of all potential candidates for direct clinical services is thus automatically carried out, both by firing line professionals and by us, in the course of preliminary clinical consultation with the primarily responsible professional person.

2. Whenever feasible we will help firing line professionals to carry out appropriate diagnostic and therapeutic procedures themselves without our becoming directly involved. (This now occurs in 8 out of 10 cases.)

3. When in the course of clinical consultation we decide it is necessary for us to provide direct diagnostic services in order to reach appropriate decisions regarding the nature of problems and how they might best be handled, and by whom, the *whole* family must come for family evaluation sessions. This means that everyone living in the household at that time must come for at least the initial evaluation session. We subscribe to the principle that the person who first comes, or is sent for help is the emissary of a troubled family. In our experience, seeing the whole family enables us much more rapidly and accurately to determine the nature of the problem, what can best be done about it, and who must be involved in doing something about it.

4. In supplying any kind of direct clinical services, we enter always into a collaborative relationship with the local professional who then continues to be primarily responsible so that seeing us becomes only one part of a total process of evaluation and treatment under the general management of the local professional. Patients and their families are not turned over to the mental health center. This is particularly well illustrated when the primary professional is the family doctor. He continues to retain all medical responsibility, including that of prescribing any required medications. (The response to this rule has been favorable. Doctors like to keep their patients.)

5. The mental health center staff will take an active hand in treatment only when the problem is one which promises to respond to brief intervention of a kind we can supply and which is not available from firing line professionals in this area.

6. Rule number six is an extension of rule number five and states that, in order that the mental health center staff have adequate time and freedom to engage in population-focused activities, no long-term psychiatric treatment of any kind will be provided at the mental health center. By the same token, no inpatient psychiatric treatment is available.

7. Family evaluation procedures must be sufficiently standardized that systematic collection of quality control research data is consistently possible.

Community Mental Health Services in a Low Population Area

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While it is true that our population is becoming increasingly concentrated around a few metropolitan centers, the majority of our states are still comprised of rural areas and small communities. The individuals in these communities, along with their local, state, and national representatives, are becoming increasingly aware of the need for mental health services. This paper is addressed to the difficulties and strategies involved in establishing mental health programs in rural or low population areas.

The forces which converge to move a community to the point that there is an effort to establish mental health facilities are often motivated by a desire for clinical services based on a treatment-cure concept of mental illness. If there has not been careful planning and consideration of alternate models, these pressures for direct patient contact will determine the clinic format. The decision is sometimes the result of careful planning, but probably more often than not is arrived at through a variety of fortuitous circumstances. The treatment-cure or direct service model is only one of the possible alternatives from which a community might choose.

The direct service model may be quite inclusive and provide individual diagnostic and treatment to a wide range of age groups and mental health problems. Alternately the clinic may specialize in a restricted range of problems or a particular age group. The direct service model is very expensive in staff time, especially if the traditional team diagnostic approach is combined with extensive use of long-term psychotherapy. With this approach a professional's treatment calendar quickly becomes filled from the diagnostic evaluations he performs in the first few weeks at the clinic. Once this time is committed new patients have to be either placed on an ever-growing waiting list or referred elsewhere. Such a model

* The ideas for this paper were gathered while the authors were consultants at the Sanford and Lee County and the Robeson County Mental Health clinics.

is not only extravagantly expensive, but also meets only a small segment of the community's mental health needs. The decision to establish a clinic based on the individual diagnostic-treatment model is often made unwittingly as a result of pressures for direct service.

An alternative to the direct contact model is one based on consultation and community service. The mental health personnel spend their efforts consulting with other helping professionals already in the community such as teachers, ministers and physicians. Such a program was established by Kiesler in Minnesota who reported that, through consultation with "firing line" professionals, direct services were reduced to an absolute minimum of ten per cent of staff time (cf. Kiesler, this journal). This procedure allows the mental health consultant to extend his effectiveness, albeit indirectly, to a significant portion of a community's population.

A third alternative is the comprehensive program which combines both an individual and a community orientation. Such a model was outlined by Knight and Davis[1] and was amply illustrated in the joint report of the American Psychiatric Association and the National Association for Mental Health.[2] The services of such a clinic include: (1) outpatient treatment, (2) part-time hospitalization, (3) emergency service, (4) consultation service for other community agencies and individuals, (5) diagnostic and evaluation services, (6) transitional and placement services, (7) rehabilitation services, (8) services to special groups, and (9) formal community education programs. Such a wide ranging program is obviously too ambitious for a small clinic in a rural area. The question which confronts the initiators, and later the staff, of a mental health service is the form the service should take. A related problem is that of staff acquisition which interlocks with, and to a large extent is dependent upon, program development. The approach to the dual problems of the development of services and staff acquisition as they were faced in a small mental health clinic in rural North Carolina will be the focus of this paper.

The Sanford and Lee County Mental Health Clinic is situated in Lee County which has a population of 26,500 (82% white) of which 12,250 live in its most populated community, and the county seat, Sanford. Seventy per cent of the residents are involved in manufacturing and white collar work, while another 18 per cent are involved in agriculture. The

median income of the white citizens is $4,652 while that of the non-white residents is $1,893. The median educational level for all residents is 9.7 years (figures from 1960 census).

The Sanford clinic was initiated through the efforts of one citizen who had a particular interest in mental health problems. He organized a committee composed of some local leading citizens representative of a variety of interest groups. These individuals formed a private organization with the aim of establishing a mental health clinic in the community. The "clinic" model was adopted in response to the perceived need for local patient care, without awareness of alternate approaches. A social worker was hired as director of the clinic on a full-time basis. A psychologist and a psychiatrist hired on a one-day-a-week basis filled out the clinic's professional team.

For the first year of the clinic's operation it would have been difficult to differentiate it from a small outpatient clinic. The social worker, besides his administrative tasks, did intakes and saw patients in therapy. The services of the psychologist and psychiatrist were primarily restricted to individual examinations and treatment. This is not to say that there was no cognizance of community responsibility, since indeed speeches were given to local civic groups and some time was devoted to case conferences with members of other agencies. Also a testing program was organized for the county schools and a pilot training program was started for a psychiatric nurse. These projects significantly helped the clinic to make contact with other agencies, and yet there was a certain lack of completeness, a lack of follow-up, and a series of missed opportunities for moving out of the direct service role. It became apparent to the clinic personnel that they would have to re-think and redirect the clinic's operations. In part, this paper is that re-thinking "out loud."

During the second year of the clinic's operation, the social worker-director left. It was clear to the two part-time professionals remaining that they would have to look for a mode of operation which would multiply the effect of their services and which would allow them to extend their contacts into the community. It was decided not to seek another full-time person until the clinic was established as a community oriented service of a quality which could attract high level professionals. There were a number of experiences which seemed to suggest methods of increasing the impact which an indi-

vidual could have on the mental health of a community.

Consultation

Individual consultation. During the early part of the clinic's life, a minister was helped to emotionally support a patient through a delayed grief reaction over the loss of her husband. The minister saw the parishioner at the hospital and later at home while coming to the clinic for weekly consultation. During the consultation sessions, the minister and the supervisor taught each other about grief and the minister's role, about crisis intervention and pastoral counseling skills, and about the theory of depression and the facts of death and loss.

It seemed to the staff that there were important lessons here. First, the success of this relationship rested mainly, we believed, on the mutuality of the interchange. Our intent was to help the minister handle a psychological problem in one of his parishioners without direct referral, but the minister for his part also helped the mental health professional to understand the minister's role in the community, the use of his skills, and the facts of life and death with which he deals. The two-way quality of the relationship differentiated it from therapy, supervision, and teaching and made it into an interchange among two professionals from different fields, both of whom had unique skills in helping and understanding people.

A second lesson was also apparent. As was documented in the report of the Joint Commission on Mental Illness and Health (1961), the minister sees many more individuals with mental health problems than does the traditional mental health practitioner. It seemed obvious that any assistance to caretaking individuals such as ministers, was an imminently more powerful way to use the limited time of the clinic personnel than was direct service. As a result the clinic staff decided to concentrate their efforts on consultation with the caretaking individuals in the community, (e.g., ministers, teachers, parole officers, physicians). In an atmosphere of mutual respect and interest our intent was to enhance their counseling skills and increase their awareness of primary prevention principles. To date, parole officers, special education teachers, welfare workers, school counselors, public health nurses, ministers, and physicians have been seen by the clinic staff.

Group consultation. The obvious extension of the individual consultation formula seemed to be group consultation. Looking back on some of the abortive attempts to establish group meetings during the first year of operations, it seemed that there were two major mistakes which caused their failure. One mistake was in seeking to organize groups with the intent of teaching them how to do their job better rather than attending to the needs, desires, and competencies of the group members. Secondly, the composition of the group, the duration of the meetings, and the goals were established without adequate attention to the needs of the group. With growing sophistication a group was organized on a different basis. A minister who had contacted the clinic previously concerning some of his parishioners was asked about the feasability of forming a ministers group to discuss problems of mutual interest. He was able to suggest persons whom he thought would be interested and who would work well together. With his counsel a group was formed which established its own goals and determined its own life course. A reevaluation session was set for the tenth meeting so that the group would continue to be self-directing and aware of its purpose. The topics which the ministers chose to discuss ranged from a sharing of professional burdens to a case-oriented exchange. At the end of the ten session trial period the group elected to continue the meetings but to change the focus of discussions. The members wanted more didactic material from the group leader on mental health problems and also wanted to structure the sessions more openly as group therapy.

As a result of this bootstrap operation we have set ourselves the following principles for group mental health consultation. The group should be established with the aid of an interested member of the target profession who could give advice on the initial group membership. Although a group so selected runs the danger of not being representative of the total profession in the area, it is more likely to include those persons who might be expected to obtain some benefit from the group experience. Once the group is established it should be allowed to chart its own course with provision for early evaluation and self-reflection.

The use of group contacts did not seem to be merely a way to handle more individuals in the same manner and with

similar goals to that of individual consultation. It seemed to lend itself to other ends. The group served as a forum for members of the same profession to discuss common problems and learn better ways of handling them. It provided an antidote to feelings of isolation and alienation which frequently arise when there is no one with whom to discuss "taboo" professional topics. The group interaction also was used as an opportunity for the professionals to see the impact which they have on others. Finally, case discussion allowed for the enhancement of their own feelings of adequacy in handling mental health problems, while at the same time provided an opportunity to learn from each other and from the consultant.

Training

Extending the services of the clinic by training persons for mental health roles seemed to be a reasonable and an appropriate function for the consultant staff. Not only is there a long tradition in various disciplines of extending services by training and supervising others, but in addition it was also an area in which the clinics had already gained some experience.

During the second six months of the clinic's existence a pilot project was initiated with the help of the North Carolina Department of Health to assess the feasibility of utilizing the services of a psychiatric nurse in a community mental health clinic. In keeping with the exploratory nature of the project the nurse participated in a potpourri of consultative, treatment and diagnostic services. These services included: consultation with individual clinic staff members, supervised individual counseling, goal limited therapy, family counseling, psychological testing, supervision of patient medication, intake interviews, home visits, liaison between clinic and referring agencies and some clerical duties. This variety of activities has much in common with those reported by Glittenberg for nurses working in outpatient clinics.

As a result of the project, several points seemed very clear. First, it was beneficial to have a full-time individual in the clinic who could provide an extension of the services offered by the part-time professional staff. Second, it was helpful to have a person who lived in, and was identified with, the community. Finally, it became obvious that training takes time

and that the staff has to be willing to reduce its patient load in order to provide supervision.

A second individual accepted for training was an advanced graduate student in clinical psychology who spent one day a week at the clinic. The goal was to provide experiences not available in traditional settings. Hence, his efforts were spent primarily in learning the techniques of crisis intervention and diagnostic examinations which utilized information from a broad range of resources. In addition to the traditional diagnostic techniques he was taught to include the family, community agencies, the schools and local physicians in his evaluation and planning. For example, in handling a court referral he worked with a local parole officer in arriving at recommendations to the court. A treatment plan was devised in which the parole officer held regular counseling sessions with the parolee and discussed the case with the psychology student at regular intervals. Even with the community orientation the student's drift toward traditional treatment and diagnostic involvements had to be constantly inhibited.

As in the previous case the training was expensive in staff time although the time was more than compensated for by the services and staff stimulation inherent in a training environment. In retrospect it seems that one day did not allow sufficient time for community involvement. A minimum of two days per week would be more ideal.

A brief check of the literature reinforced an interest in training as a mode of upgrading the clinic functions and extending more services into the community. Mature adults without previous training in the mental health disciplines have been found to perform quite adequately in a variety of mental health tasks including history taking, routine psychological testing, and various types of goal limited psychotherapy. Margaret Rioch, for example, has described a well thought out and controlled program for training housewives as mental health counselors.[4] Mature adults without previous training in the mental health disciplines also have been found to perform quite adequately in a variety of mental health roles in North Carolina (cf. North Carolina departmental reports).[5, 6] Initially, these trainees take a substantial investment of training time, although the dividends to be accrued well outweigh the initial cost. Besides performing a much-needed service, mental health aides or technicians who reside in, and are a

part of, community life provide a basis for local mental health education and action. The use of local housewives with training and experience in education seems to be one way for a clinic to expand and extend its services into the community. These individuals could help with a myriad of educational diagnostic tasks, remedial work and school consultations. Such a program has been initiated by the writers in connection with a school testing program sponsored by the Robeson County Mental Health Clinic.

A North Carolina advisory committee studying the feasibility of training mental health assistants took cognizance of dangers inherent in establishing a new sub-professional group.[7] They called attention to possible public confusion about the qualifications of these mental health professionals and their range of skills; the fear that these new assistants might be tempted to engage in independent activities beyond their competences; and the possibility that such assistants might be used in the absence of proper supervisors to alleviate the clinic load. Despite these potential dangers, the realistic needs of the clinics and the extreme shortage of professional manpower are matters of fact. More research and demonstration projects are needed to assess the wisdom of establishing the sub-professions which our needs seem to dictate.

Direct Services

Although to this point the direct services model has been minimized and castigated as expensive, and possibly even anachronistic, in fact, a community expects locally available, direct patient service. Assuming that at least some aspects of this service need should be met by a community clinic, the staff proceeded to explore how much services might be provided. One approach was to initiate a one-day-a-week drop-in service in which patients were provided with an initial evaluation, brief treatment, consultation or advice. In addition, long-term treatment at the clinic was prescribed, making possible contact with a larger number of patients. Short-term treatment techniques include crisis intervention, time-limited therapy and family counseling. Each of these interventions allows professionals to contact a relatively large number of patients in a manner which has not been shown to be less effective than more traditional modes. There is growing evidence from the Rush Center in Los Angeles and the Trouble

Shooting Clinic in New York that interventions which run from three to ten interviews are highly effective with a broad range of patients.[8, 9]

Diagnostic evaluations can also be quite time-consuming if handled in a traditional fashion. Knight and Davis have stated in this regard that team diagnostic efforts are a luxury we can ill afford.[1] The diagnostic appraisals at the Sanford clinic are handled primarily by a single mental health professional with related professionals available on a consultative basis.

Multiple utilization of the services is another method used at the clinic for expanding the effectiveness of the mental health professionals. Each direct service case can be combined with other clinic functions such as training, community relationships, demonstration or research. For example, public health nurses who refer children to the clinic are sometimes asked to sit in on the diagnostic evaluation and the interpretation of the findings to the parent. In this manner, the clinic hopes to increase the nurse's awareness of psychological problems and methods which she might use to deal with them. Similar training methods have been used for teachers and social welfare workers and could easily be extended to other groups. The multiple use of direct service contacts makes an asset out of an obligation.

Research

A well planned research program clearly holds promise for efficient mental health intervention, but at the same time provides the least patient contact. Research, whether epidemiological or evaluative has little immediate payoff and therefore is very likely to be assigned low priority by the clinic personnel. At Sanford, for example, there is the beginning of an epidemiological or evaluative study, but over a period of a year it has developed little beyond the early data collection stage. A second project, an evaluative one, is also in the early stages of development. An attempt is being made to identify those patients who are most likely to benefit from specific types of interventions. All of these research plans, however, are getting short shrift in spite of desires to the contrary.

Staff Acquisition

The Sanford clinic, like many clinics in small towns, has had difficulties in obtaining qualified full-time personnel. It

seems that the advantages of a small town, or the special assets of a particular community, are frequently overshadowed by the glamour of a metropolitan area or university setting. The small clinic is frequently left with a choice between hiring less well qualified professionals or none at all. The advisory board and consultant staff at Sanford chose not to hire full-time staff until it was possible to attract fully qualified individuals. This decision grew out of an awareness that the results of hiring staff members who are incompletely qualified may be an expedient today, but can well result in the stagnation of the mental health program tomorrow. Hubert Dorken counsels that when the salary, conditions of employment, and training standards are insufficient the positions are unlikely to be filled and professional standards are progressively lowered.[10] Once an inferior staff has been recruited, the agency is deprived of the caliber of staff originally needed, the less qualified staff is usually less mobile, and the responsibilities they take on are inappropriate. In addition, the presence of an inferior staff makes the recruiting of better qualified individuals even more difficult.

In cognizance of the consequences of poor staff acquisition patterns a three-stage recruiting strategy was planned at the Sanford clinic. There is no guarantee that this "strategy" will work but the three stage program which will be described does seem to be progressing as anticipated. The first stage of the strategy consists of consultant procurement and program development. The second phase consists of the development of a training program. The third stage is the recruitment of full-time staff.

During the initial phase, the clinic seeks to employ consultants capable of developing the broad based program of consultation and service outlined in the first part of the paper. Once the program is established, the clinic becomes an attractive facility for field training in community mental health work and thus enters the second phase of development. It may take some time to establish these services to the point where the clinic is operating well and ready to become a training agency in community mental health.[11]

During the second stage a variety of lay individuals, semi-professionals, and professionals in training are affiliated with the clinic. Assistance for this training may be sought from local community colleges or universities and from related

agencies, thus serving both to accent the broad and reciprocal relationship between the various facilities and to increase the size of the training staff. The Sanford clinic, as was mentioned, is presently moving progressively into the second stage of development. It is anticipated, for example, that in the next year the trainees will include a mental health aide, a post-internship student in clinical psychology, and a clinical psychology intern. The efforts during the coming year will be to establish the Sanford clinic as a training ground for these individuals, while continuing to cement and expand the services to the community. By the time the clinic is ready to move into the recruitment stage it is hoped that it will have a stimulating training atmosphere and a close working relationship with a nearby university.

With the addition of full-time personnel the use of consultants becomes less necessary with respect to program development and continuous service. As the clinic becomes more autonomous, consultants will be used for the more traditional functions of in-service education, specialized assistance in treatment and diagnostic problems and research planning.

There is, of course, no guarantee that the clinic will be able to get the type of professionals desired. The demand for these people is overwhelming and the output from professional institutions, particularly the output of those trained for community mental health positions, is less than a trickle. However, if the clinic has an attractive treatment program, training opportunities, and professional affiliation with a training institution, there is an increased likelihood of hiring highly qualified, well-trained individuals who are comfortable with a community oriented mental health program.

Summary

The program presented in this paper is only one program of a large variety of possible attempts to provide mental health services to a local community. Other solutions may be more appropriate in different circumstances or surroundings. The Sanford program is grounded in the availability of consultants from nearby universities and private practice. Other arrangements may well work out in different locales. For example, a community may want to extend itself financially in order to hire a highly qualified person who would serve as the

nucleus of the mental health service. This person may then train appropriate citizens of the community to increase his impact and spend most of his own time in supervision and community consultation. The writers believe that any mental health program must be based on a competent staff which extends itself into the community through a variety of training and consultative arrangements.

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Sociological Aspects of the Community

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When we examine aspects of the community that may have relevance to mental health, it may be well to start by looking at some of the chief characteristics of communities in the United States today. Communities vary enormously, and a rural community is not the same thing as a large city, but all contemporary American communities have things in common which stem from their being, to some degree, microcosms of the larger society of the United States and the western world. What then are some significant features of communities today?

Features of Contemporary Communities

For one thing, they have *highly differentiated social structures.* A differentiated social structure is one with a large number of specialized groups and organizations. Each person takes part in a number of such specialized groups, in specialized social settings. In each one he plays a different social role. An ordinary man may be his wife's husband, his children's father, his parents' son, his boss's employee, his church's member. He may be affiliated with a lodge, a professional or business or labor or farm organization, a bowling league, a P. T. A., and still more groups. Even people who are not "joiners" of organizations are affiliated with a complex web of family, work, neighborhood, and friendship groups even though these may not be formally organized.[1]

Another feature of social differentiation and of modern communities is that any community is likely to contain a *variety of subcultural groups,* social classes, religious denominations, and so on, each of which has a way of life and a set of values and beliefs somewhat different from the others'. Catholics, Presbyterians, and members of Pentecostal sects do not live exactly alike, or think alike. Neither do the rich and the poor. Neither do people in different occupations, even of roughly the same social class level: doctors and businessmen, or farm tenants and factory laborers, for example. Each one of these categories of people may have at least some beliefs and culture patterns which set them somewhat apart from others in the community.

Still another feature of contemporary life is a large amount of *migration.* A high percentage of our adults are not living in the same communities where they grew up. This is especially true in growing cities, but it is also true in small towns, many of whose people may have come from other towns or especially, from farms. Migration, like differentiation, involves people in different sets of values, beliefs, and behaviors. This is most obvious in the case of people who live in towns after growing up on farms, but it may also be true of people who move from one region to another, or from small towns to big cities. The move may subject them to ideas and behavior patterns quite unlike the ones they are accustomed to.

Related to migration and social differentiation in another feature of contemporary life, *social mobility*: shifts of an individual from one social class or occupational level to another. Many people grow up, for example, in working-class or farm homes, and through education move up into white-collar occupations. Only a small percentage of Americans stay in the same job, or even the same occupation, throughout their lives. During his lifetime a man may work at several different kinds of jobs, and the changes may involve him in movement up and down the social class ladder. These social moves may expose the individual to different kinds of people, in differing social classes, with differing values and beliefs. We have been speaking of men and their occupational shifts for illustration, but the same thing happens to a woman who grows up in one social class and marries a man in a different one, or who experiences the ups and downs of her husband's career.[2]

Finally, American society and all the communities in it are undergoing continuous *social changes.* Within this century we have come from horse and buggy to jet aircraft, from a predominantly rural and small-town pattern of residence to a predominantly urban one, and from a situation in which only a privileged minority finished high school to a situation in which college attendance is rapidly becoming the norm.

None of these features of contemporary communities is entirely new. We have always had social differentiation, subcultural variety, migration, social mobility, and social change. But all of these things have reached an unusually high degree of development in the modern world. We have more of them than our grandfathers had.

The effect of this is to subject people today to a wider and more shifting array of values and beliefs than has been usual in human history. A further effect is to expose people to *cross-pressures* from different groups in their social environment and, hence, to *role conflict* in which they are pushed in different directions simultaneously. A man may grow up being taught by his parents that one kind of behavior is right, then find that his wife and his friends think that an entirely different kind of behavior is right and that the ideas he grew up with are old-fashioned or silly. Or he may find that his wife, his parents, his work associates, and the members of his church expect contradictory kinds of behavior of him.

To the extent that he is cross-pressured by different groups he considers significant, he is put in a difficult position. A teenager whose parents oppose drinking but whose friends define the nondrinker as a "creep" provides a simple example, and in a differentiated multi-group society there are other instances less obvious than this, in which the values of a person's significant groups may differ. A person in such a situation cannot win. He can opt for one of the opposing values and end with guilt, shame, or open conflict; or he can "leave the field," as some of the Gestalt psychologists put it, by doing nothing, becoming immobilized, like the jackass in the parable who found himself half way between two bales of hay and starved to death because he could not decide toward which one he should move.

Sociologists have provided many illustrations of this sort of immobilization by cross-pressures. In one well-known study of voting habits in Erie County, Ohio, it was found that if someone was wealthy and Protestant he was extremely likely to vote Republican; if he was poor and Catholic he was almost certain to vote Democratic; but wealthy Catholics and poor Protestants were cross-pressured, with different voting prescriptions coming from their religious and social class affiliations. These cross-pressured voters tended to vacillate between the two candidates during the election campaign, to make up their minds later than other voters, and to stay away from the polls on election day in greater proportion than other voters, unable to reconcile the conflict.[3] This is not to suggest that people have mental breakdowns when they cannot decide how to vote in an election; but the principle of cross-pressures also operates in matters more central to the

self and with greater implications for mental health and successful social adaptation.

Our point is not simply that cross-pressures sometimes occur. It is that they are more likely to occur today than in the past. The values and behavior prescriptions in communities today are more diverse than in the past, and the individual is more likely to be affiliated with a variety of social groups and organizations than his grandfather was, because the structural differentiation of society, the number of specialized social groups and subcultures, and the other factors making for cross-pressures are at a new high. A person today is likely to experience intimate contact with groups which suggest widely differing values to him—much more likely than was his grandfather, who may have lived all his life in a fairly homogeneous rural community where differences in wealth were slight, where everyone farmed, and where everyone was of the same religion.

The Contemporary Family

Let us look at another kind of illustration of how the differentiation of modern communities has implications for mental health. This illustration concerns the family.

Another way to think of differentiation is to say that in a differentiated community, various "functions" (activities) are handled by specialized social groups rather than by a smaller number of multipurpose groups such as the family. In the process of differentiation that has taken place in the western world, a number of functions once handled by the family have been shifted to specialized groups outside the family. The family is no longer, for most people, an economic producer; instead, men leave home to work in offices, shops, and factories. Much of the function of socializing the young has been taken out of the home, into schools set up for this purpose. Religious, protective, and other functions have been taken over by specialized agencies: churches, the police, and others.[4]

This removal of functions from the family has left it to concentrate more heavily on those that are left to it, notably the providing of affection and emotional warmth and the cultivation of individual personality development. And there is reason to think that the contemporary family can handle these functions better than its predecessors could. For example, it

is a general principle that emotional closeness and companionship are not wholly compatible with authority relations.[5] Relations between boss and employee are apt to be somewhat distant and impersonal. The subordinate may hestitate to reveal all of himself to someone who may punish him if some of the self is displeasing, and the boss may feel that familiarity breeds contempt. This being the case, a modern father is better able to be a "companion" to his sons than was the father in a society where the father spent much of the day as the boss of a family farm labor gang. The modern father, in fact, has little to do with his sons beyond being a companion to them; and there is some anthropological evidence that the relations between fathers and sons today are much closer and freer than in traditional societies where the father was a stern authority figure managing a family enterprise in which the sons were laborers.[6]

Similarly, with less coordination of work needed in the family, and with fewer family duties incumbent on the members, there is more room to allow each individual to "be himself" and cultivate his own tastes and interests. Putting the matter somewhat differently, today's family, compared with a traditional rural family, has less definition of family roles imposed on it, since with fewer functions it has less need of rigidly defined roles. This leaves each family to work out its own role structure, within broad limits. It has great flexibility and can tolerate an amount of individual freedom which would not have been feasible when more close-knit coordination of roles was required.[7]

So far, so good. Companionship and freedom are desirable. But there are two other elements in the situation that can cause trouble. For one thing, since not much is left to the family but warmth and companionship, things are very bad if for any reason these are lacking. The development of the romantic love complex has accompanied the shrinking of family functions.[8] We marry for love, are disturbed if we do not get it. If love, or at least emotional warmth, is absent, there is nothing left to make the whole effort seem worthwhile. Historically this is an unusual situation. In most societies, love between husbands and wives has been considered acceptable, a pleasant luxury if it happened, but not a requirement for family life, since family life was built around a well defined set of role obligations related to the functions (mainly

the economic ones) of the family. Husband and wife could go about their business whether or not they found each other's personalities pleasing. They did not have to worry about *creating* their own role structure based on companionship.

To complicate matters further, the very companionship which has become so important has been made more difficult by the differentiation of society. Husband and wife may come from different kinds of backgrounds, have different values, and have different notions of how they ought to behave. The probability is much higher that a young couple who meet, for example, at work or in college and have come from differing backgrounds will find after marriage that their values are incompatible, than a couple who grew up on neighboring farms a century ago would entertain conflicting ideas about the important things of life.

Add to these conditions the increased likelihood that the children will learn from their friends at school that *both* parents are all wrong about everything, and the fact that the expansion of economic opportunities and suitable housing arrangements for unattached women have made divorce and separation more feasible, and we have a situation ready-made for family conflict, frustration and divorce.

Behavioral Alternatives and Opportunity Structures

So far we have been examining some harmful effects of social differentiation in modern communities. The good side of the picture is greater freedom of choice: do what you like in the family setting; choose your own occupation; if you dislike your community or your place in it, simply find another one. Alternative group affiliations and ways of life have never been in greater supply than today. This means that those social critics who cry out against our "age of conformity" are in error. There has never before been as much structural opportunity for nonconformity as there is today, because communities today offer more alternative ways of life than communities have offered in the past. Sinclair Lewis found no beatniks on Main Street. Perhaps the great profusion of alternative choices makes the need to conform to some group standards—without which no human community could endure —more visible. A member of a monolithically homogeneous community may not reflect on the fact that he is a conformist,

just as a fish may not reflect on the wetness of his surroundings.

The availability of alternative modes of life may mean, for some people who are unable to get along in their present situations, that satisfactory adaptation to the present situation is not the only possibility. Moving to a new situation may be the best solution, and this is more possible now than it once was. In a way this is paradoxical. Viewing the person in his social-environmental milieu and seeing his problems as the result of cross-pressures arising from this milieu might lead to a highly *individualistic* solution for his problems: instead of trying to adapt to the situation, leave it and find another.

But it is easier to say this than to do it, even in the case where the man's problems arise from his work and are therefore most amenable to this kind of solution. We live in a society where increasingly complex skills are required for even the simplest of jobs, and where having a secure and respectable job is a *sine qua non* for the social adjustment of males—and for many females too, since those with mental health problems are especially likely to have broken families and to be competing in the job market. What is new is not the complexity of work as such, since most manual and clerical jobs today are much easier to learn than farming is; but today we do not learn the needed work skills in the family in the normal course of growing up, and therefore there are people who never learn them anywhere. To have a satisfactory work career means taking advantage of available *opportunity structures*. An opportunity structure is an available set of means to attain one's goals. Going to college in order to get a good job would be an example of a socially approved or *legitimate* opportunity structure. Let us look at the notion of opportunity structures and their availability in modern communities.

Robert K. Merton, a sociologist, has devised a neat scheme to portray the possible combinations of whether a person (a) seeks the goals his society approves of, and (b) uses the socially approved means to reach these goals.[9] He is discussing chiefly the goals of economic success in American culture, but his scheme could be applied equally well to other kinds of goals.

	Seek Approved Goals	Use Approved Means	Examples
Conformists	+	+	Most people

Innovators	+	—	Criminals
Ritualists	—	+	Hard workers getting nowhere
Retreatists	—	—	Those who have given up: skid row habitués, the socially withdrawn
Rebels	$\frac{+}{-}$	$\frac{+}{-}$	Those who reject the approved goals and means but substitute their own

From the standpoint of social role performance, conformists and ritualists are equally satisfactory for the social system. It operates if they do what they are supposed to do, regardless of whether they are reaching any personal goals. But we would not consider the ritualist to be in a satisfactory state of mental health. The innovating criminal, if he is successful in his crime, may be a paragon of mental health but he is bothersome to the community. The same may be of the successful rebel. Only the retreatist is clearly in bad condition by both the societal and the individual standards of evaluation. People who might at first glance appear to be successful retreatists, such as Trappist monks, are not really retreatists according to this scheme; they are rebels, since they have adopted new success goals and found ways to achieve them.

Other sociologists have expanded upon Merton's basic formulation in an effort to explain different types of juvenile delinquency. Albert K. Cohen in 1955 published a theory to explain "conflict" gangs that engage in seemingly senseless vandalism and aggression, and his theory makes the members of these gangs "rebels" in Merton's terminology.[10] According to Cohen these boys are those who do poorly in school, primarily because their lower-class backgrounds put them at a competitive disadvantage in the middle-class world of the school. To erase the sense of failure this creates, they join in gangs and establish their own deviant set of values. Everything the middle-class world as represented in the school defines as good, they define as bad, and vice versa. Thus to them, truancy is good and vandalism is good; respect for constituted authority is bad; and so on. In this way they can succeed by their own standards and achieve a sense of worth. The boy who is the worst scholar can still be the toughest street fighter. Thus they substitute a new opportunity structure—though ultimately a self-defeating one—for the approved one.

Richard A. Cloward and Lloyd E. Ohlin in their book *Delinquency and Opportunity* point out, however, that not all juvenile gangs are of the conflict type, and that most juveniles who cannot pass muster in the legitimate opportunity structure of the school and work place would actually prefer to be apprentice criminals: innovators, in Merton's terms.[11] Apprenticeship in organized crime brings greater rewards than street fighting or vandalism, and it creates less trouble with the police, since the organized underworld offers supports for its members who are in danger from the police.

In addition to rebellion (conflict) and innovation (organized rational crime) there is a third mode of delinquent reaction to failure: retreatism, giving up the goals as well as the approved means of the conformist. Boys who get their kicks from drugs are retreatists. Thus we have in Cloward and Ohlin's formulation the following kinds of boys, classified by Merton's scheme:

Conformists: ordinary "good" boys who use the legitimate opportunity structure of the school and job market.

Innovators: apprentice criminals, working their way into the illegitimate opportunity structure of organized crime.

Ritualists: "good" boys who try hard in the approved manner though they get nowhere and may have no long-range success goals.

Retreatists: drug users, among others who have withdrawn from the rat race. Drug use can be solitary but usually requires group support and contacts to assure a source of supply.

Rebels: street-fighting "conflict" gangs.

Cloward and Ohlin point out that not only the legitimate, but also the illegitimate opportunity structure (organized crime) is often inaccessible to many boys in our cities. Members of minority groups such as Negroes, Puerto Ricans, and hillbillies from the South, for example, not only are disadvantaged in school; frequently they cannot even gain acceptance into the underworld, which is dominated by other ethnic groups. It is among these "double failures" that we find retreatist and conflict gangs most prevalent. The effect of being denied both legitimate *and* illegitimate opportunities is to push a lot of boys who would rather be apprentice criminals into drug use or senseless aggression. Thus Cloward and Ohlin note that while the main forms of organized crime in the cities are controlled by whites, Negroes and Puerto

Ricans are overrepresented among drug users and street fighters. The assumption is that these people would prefer to be apprentice criminals if they knew how, just as apprentice criminals would be legitimate businessmen if they had the chance.

CONCLUSION

To be aware that the lack of suitable opportunity structures or even of unsuitable ones can create *varying modes* of failure and of adaptation to failure can be helpful in understanding the varying modes of mental health problems that people encounter in contemporary communities. Similarly, to keep in view the high propensity of modern differentiated communities for putting the individual under emotional cross-pressures is often useful in approaching problems of mental health in the community. The man with personality impairment stemming from early childhood, the man faced with situational cross-pressures that might be alleviated if he changed his situation, and the man who lacks access to opportunities to achieve vocational or other goals pose different kinds of mental health problems, which may require different methods of attack. It may not help a man, if his trouble is occupational failure, to diagnose his underlying personality or his family situation—although unemployment and a sense of occupational failure can create family strains and aggravate personality disturbances.

If the source of problems lies outside the individual, outside his family, and outside the part of his environment he personally can do anything about, then none of the mental health professions, singly or collectively, can completely deal with the problem. At this point we reach the realm where mental health practitioners, like other professional and business people who have special skills and who command respect in the community, have to bring their skills and knowledge into the forum of public discussion and try to influence public policy. Sometimes a political solution is needed, if the problem lies not in the individual but in his community and society.

FOOTNOTES

1. Differentiation is a concomitant of the division of labor, whose role in modern society has been stressed by a long line of scholars since Adam Smith. See especially Emile Durkheim, *The Division of Labor in Society*, translated by George Simpson,

Glencoe, Ill.: Free Press, 1947. For a somewhat exaggerated but still useful analysis of many of the features of contemporary urban life with which we are concerned, see Louis Wirth, "Urbanism as a Way of Life," *American Journal of Sociology*, 44 (1938), pp. 1-24.

2. An excellent survey of research on social mobility is given in Seymour Martin Lipset and Reinhard Bendix, *Social Mobility in Industrial Society*, Berkeley and Los Angeles: University of California Press, 1959.

3. Paul F. Lazarsfeld, Bernard Berelson, and Hazel Gaudet, *The People's Choice*, 2nd ed., New York: Columbia University Press, 1948. The term "cross-pressures" is from this study, and the illustration of voting in Erie County, Ohio.

4. William F. Ogburn, "The Family and Its Functions," in *Recent Social Trends in the United States*, Report of the President's Committee on Social Trends, one-volume edition, New York: McGraw-Hill, 1933, pp. 661-708.

5. George C. Homans, *The Human Group*, New York: Harcourt, Brace, 1950, pp. 33, 244-248.

6. *Ibid.*, pp. 244-245.

7. See Nelson N. Foote and Leonard S. Cottrell, Jr., *Identity and Interpersonal Competence*, Chicago: University of Chicago Press, 1955, for a related discussion.

8. A cross-cultural analysis of romantic love and its significance is given in William J. Goode, "The Theoretical Importance of Love," *American Sociological Review*, 24 (1959), pp. 38-47.

9. Our discussion and the chart portraying Merton's scheme are based on Robert K. Merton, *Social Theory and Social Structure*, 2nd ed., Glencoe, Ill.: Free Press, 1957, pp. 131-160.

10. Albert K. Cohen, *Delinquent Boys: The Culture of the Gang*, Glencoe, Ill.: Free Press, 1955.

11. Richard A. Cloward and Lloyd E. Ohlin, *Delinquency and Opportunity: A Theory of Delinquent Gangs*, New York: Free Press of Glencoe, 1960. For discussions and refinements of the Cloward and Ohlin "opportunity structure" theory and related theories see Richard A. Cloward, "Illegitimate Means, Anomie, and Deviant Behavior," *American Sociological Review*, 24 (1959), pp. 164-176; Clarence Schrag, "Delinquency and Opportunity: Analysis of a Theory," *Sociology and Social Research*, 46 (1962), pp. 167-175 David Bordua, "Delinquent Subcultures: Sociological Interpretations of Gang Delinquency," *Annals of the American Academy of Political and Social Science*, 338 (November, 1961). For a study that supports most of the predictions of the theory as reported here, though with some anomalous findings on racial differences in perception of illegitimate opportunities, see James F. Short, Jr., Ramon Rivera, and Ray A. Tennyson, "Perceived Opportunities, Gang Membership, and Delinquency," *American Sociological Review*, 30 (1965), pp. 56-67; and James F. Short, Jr. and Fred L. Strodtbeck, *Group Process and Gang Delinquency*, Chicago: University of Chicago Press, 1965, forthcoming. Our discussion is based on the Cloward and Ohlin book cited above.

A State's Concern in Community Psychiatry

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A. INAPPROPRIATE DEPENDENCY ON STATE INSTITUTIONS

1. *An Example to Think On*

Let us think about some recent examples in the state of Georgia relating to our subject, "A State's Concern in Community Psychiatry" and the general theme, "Community Mental Health."

I have a news item from the ATLANTA JOURNAL of January 14, 1965, and an editorial from the ATLANTA CONSTITUTION of January 15, 1965. These are entitled, "Hospital Transfers Seen in Bid to Save $1 Million" and "Fresh Look at Problems of the Aged." The story concerns action in the State Senate which involved approval of an additional $37,000 to a $4 million deficiency appropriation. The objective is "the transfer of 1,149 non-psychotic patients over sixty-five at Milledgeville State Hospital to private nursing homes." One paragraph in the CONSTITUTION'S editorial states, "If the 1,200 or so non-psychotic senile persons in Milledgeville could be placed in nursing homes, the state's per patient cost for them would be reduced from $110.00 a month to about $35.00 a month, and more important the serious overcrowding at the hospital could be alleviated." The state's one mental institution at Milledgeville maintains a daily census slightly over 12,000. Admissions, now running at the rate of around 7,000 per year, have doubled in the last four years.

This effort represents action at top levels of decision-making in state government to do something about the present inappropriate dependency on state institutions. In Georgia, county courts can decide that a person will be accepted into the state institution. One major concern of the state government (and I will be using "state"

primarily to represent "state government"), is to reduce what Dr. Addison Duval calls "the overuse of state hospitals."

2. *Reducing Over-use of State Hospitals*

This over-use of the state mental hospital takes many forms. For example, there are more mentally retarded persons in Milledgeville State Hospital than there are in the state institution for the retarded at Gracewood. The situation, in light of modern development, raises the question of whether this special community which provides living arrangements for 12,000 citizens actually is still appropriately called a "hospital." There is a conviction in many quarters that a large number of people are at the state hospital simply because appropriate living arrangements have not been made in their home communities. Looking for ways to reduce the over-use of the state institution takes us in many directions. When I returned to Georgia in 1957, the chairman of a joint legislative committee urged me to make a statement that since mental illness was a medical problem, the state hospital should be transferred to the state health department. (This was 1½ years before the transfer actually occurred in April 1959.) Although it was a medical problem, it was also many other things. I inquired, suppose all the buildings at Milledgeville State Hospital burned, and all the people were saved and returned to their communities. Would the physicians in the community absorb the load at the local level? Would the hospitals?

About two weeks ago this question was being discussed at the meeting of the Technical and Scientific Advisory Committee to the current planning project in the department. Dr. Duval reported that the Board of Health inquired about an intensive educational program which would aim at cutting down on inappropriate referrals of older persons to Milledgeville Hospital. The chairman of the committee, a psychiatrist, raised a question whether anything would be quite so effective in the way of education as a firm stand on the part of the state, setting limits to services that would be offered by the state institution.

3. *State Perspectives of Financial Pressures*

My administrative experience in three states has impressed me again and again with the diffuseness of decision-making power within the structure of state governments. It has also impressed me with the ways the awareness of financial problems and pressures influence decisions at many levels. Back to the clipping from the newspaper, notice the thinking behind this statement, "In its report, the committee said it was astounded that the state 'is spending approximately $110 per patient per month for the care of aged patients who are sane.' The total annual cost at this rate is $1,516,680.00. By transferring the patients to private nursing homes, federal funds are available under the Kerr-Mills Act to pay for 80 per cent of the cost. The state's share of $175.00 that would go monthly to the nursing homes would be $35.00. At this rate, the state's share of expenses would be $482,580.00 annually, a saving of slightly more than $1 million a year."

The federal debt has increased 20 per cent since 1945. Generally we are less aware of the fact that debts incurred by state and local governments in the United States have increased by 455 per cent since 1945 (Federal increase from 258.7 billion to 311.7 billion. State and local increase from 16.6 billion to 92.2 billion.) It is worthy of note that expenditures for goods and services by state and local governments in 1965 will exceed such expenditures at the federal level for the first time since 1950. The estimate for annual expenditures by state and local governments for the current year is 69.3 billion compared with 65.6 billion for federal.

The time has passed when the state government can be expected to carry the load for the cost of mental illness. This must be shared at all levels of tax-supported programs. Despite the reluctance to increase the size of federal government, it is easier for spokesmen for state legislatures to look to federal dollars than it is for them to make demands on local communities for providing more funds. It is important to remember that dollars represent only one type of resources for meeting needs. Perhaps the greatest opportunity lies in developing more effective ways for utilizing human resources aside from

the dollar cost, and to do this at the local level, as close to the responsible individual as possible.

B. ACHIEVING BALANCE IN SHARED RESPONSIBILITIES

1. *Private and Public Responsibilities*

The proposal to move 1,000 patients from a state institution into nursing homes, and to utilize 80 per cent federal funds to pay the costs presents one set of problems when this is thought of as a wholesale movement, and another set of problems when looked at in terms of each individual involved. Theoretically it is expected that the families and patients who have the ability will pay the cost of patients staying at the state hospital. Of the many complex questions which arise in relation to such payments, one reflects a very interesting aspect of the balance between private and public responsibilities. Organized medicine in the state made a formal request sometime ago that the portion of the per diem cost of hospitalization which represented service provided by physicians should not be collected, on the basis that this would constitute the corporate practice of medicine. At a recent discussion concerning the proposed transfer of patients to nursing homes, a distinction was made between two different ways of perceiving this transfer. One would be as an interagency arrangement where the state welfare department (which is now officially called the Department of Family and Children's Services) would cooperate with the state mental institution in making arrangement for these patients. Another would be that before the Department of Family and Children's Services can take on the patient as a client, he must be discharged from the hospital, and he then has the choice of whether to receive assistance from the welfare department and remain at home, or have the welfare department pay the $175.00 a month for care in a nursing home. It is easy for this necessary regard for the rights of the individual to be perceived as a hurdle or a nuisance from the standpoint of completing a wholesale job on this. The legal, medical, and ethical ques-

tions that arise have to do with the general question of when one person has the right or responsibility to interfere in the life of another person. This is by no means limited to public agencies. It involves family situations. The responsibility of a public program to furnish financial assistance to a citizen in need is set up with ample safeguards in law and regulations for protecting the rights of the individual thus helped. Such a client is not subject to the kind of legal authority which is represented by the guardianship which in some instances a superintendent of a mental institution has over persons in the institution. We are concerned, then, not only with questions of appropriate financial support from private means, as compared with public means. We are also concerned with questions of the extent to which a publicly supported program has a right to make decisions concerning the life choices of the individuals who are served. The direction of help lies in the maximum ability of individuals to assume responsibility for their own lives.

Furthermore, any program of action under the governmental agency should stimulate an increase in private responsibility for benefits which are provided in governmental programs. It is easier to accept the reverse expectation, that public programs will take over responsibility for broad application of those things which are developed on a private basis. It is essential that the flow occur in both directions, and that private responsibility relieve public programs for some things, while public programs relieve private responsibility of others. The Sabin Oral Sunday program for administration of polio vaccine is a good example of this principle in practice. The field of mental health probably offers the richest opportunity for development of this principle.

2. *State and Local Responsibilities*

It is interesting to note within our own state mental health programs in Georgia four different levels of ways in which state and local responsibility is shared.

a. Local authority can make the decision on placing persons in the state mental institution. One might

say a waiting list could be established, but the perception is that such a step would make the superintendent of the hospital liable for contempt of court charges.

b. The Community Hospital Psychiatric Program, in which general hospital psychiatric service is purchased for voluntary patients referred through local health departments, operates on a statewide basis. However, in this program the local health department submits an application which may or may not be accepted by the psychiatric service in the general hospital, which then submits the bill to the state for payment.

c. Another program that operates statewide is the nursing services to families of the mentally ill which operate as a regular part of the public health nursing program in local health departments throughout the state.

d. Our local community mental health programs operate on a county (or in two instances a multi-county district) basis, and we have no statewide coverage, (with the exception of consultation service, about which more is said below). Only twelve of the local health departments employ professional mental health staff members for the operation of clinic and consultation programs.

We are now faced with the question of sacrificing statewide coverage on the Community Hospital Psychiatric Program, in order to intensify the development of combined local programs. I have recommended that we adopt the same philosophy for the general hospital program that we operate on for the health department mental health programs. In essence this is a philosophy of utilizing state and federal dollars to help those counties that help themselves. New matching formulas are under study. We have not developed a new model agreement as in North Carolina.

It has been quite surprising to observe the degree of confusion that exists in discussion of community mental health centers. It is clear that these would be operated under the authority of local operating bodies, in contrast

to state-level operations as in state institutions. There is still confusion when interested groups discuss the concept of regional state hospitals, and their relationship to community mental health centers. Achieving appropriate balances in state and local responsibilities is one of the most important issues that faces us. I know of no more vital interest to state governmental programs at the present than the task of breaking once and for all the stereotype that the state should have sole responsibility for mental health programs. This is essential not only because of the financial facts of life; it is also important because the direction of placing more responsibility at the local level is in line with the vitally important principle of moving the responsibility as close to the individual concerned as is possible.

3. *Services to the Sick and to Total Population Groups*

Is senility a mental illness? When does transient memory loss result in a person's being dangerous to himself or to other people? It appears to me that it is becoming increasingly difficult to decide when a person is "sick" and when he is involved in other types of trouble. Even if we accept the idea that troublesome persons are usually troubled persons, where do we draw the line? And who needs the attention of the professional helping person? Is it the person himself, or someone in his family who will help that person make a decision? Personally, I don't feel too competent to define what constitutes a "mental health problem" and what does not. In our consultation with interested persons in local communities, we have stressed the idea that probably the best definition of a mental health problem in any one community can be arrived at by having a group in that community who share responsibility actually "get down to cases." By pointing to a specific situation, which occurred in the community, people can decide whether or not that particular situation represents what they consider to be "a community mental health problem." We have talked about the shortcomings of what might be referred to as the "mass production type of program." By this we mean simply attempting to duplicate some popular national stereotype. This would be in contrast

to what might be called a "custom designed program", based on a careful study of the actual needs and resources in that community. It is a difficult thing to get away from the concept of the clinic as a magic touchstone for solving community mental health problems. The program of the publicly supported health agency has a responsibility to be concerned with the health of the total population. This does not mean that it controls the vast range of services offered by autonomous professionals and agencies to meet the needs of persons in the community. One distinction we make is that a public health program should be busy finding ways to promote the health of the entire population, in contrast to the hospital program which should be more centered in the treatment of persons already sick. Even this concept of limiting the hospital to the treatment of the sick has been replaced by the view of the hospital as a medical center concerned with health as well as illness. It is difficult to keep a balanced perspective in program planning between services to the sick and services aimed at a higher level of health for total populations.

One of the best outlines of the total perspective in the community mental health field appeared in the first annual report of the Joint Commission on Mental Illness and Mental Health. I was quite disappointed in the lack of balance in the final report, which did not include a copy of the splendid series of outlines which appeared in section F of the first annual report. (Some reprints of this are available.) This is similar to the excellent little booklet Dr. Hollister prepared which has been so helpful entitled, "An Overview: Providing Better Mental Health for Our People—An Introductory Manual for Mental Health Workers." Programs limited to serving people who are already sick or disabled will never make significant gains against the problems of the magnitude of illness in a total population. Even at the risk of leaving some needs of the sick unmet, a practical approach calls for a balanced program dealing both with the sick and with the non-sick members of any population group. Whether one would make a distinction between community psychiatry and community mental health programs in line with these differences seems to

be a matter of personal opinion, without any concensus in the field as of the present.

C. WHO DOES WHAT, AND HOW

1. *Evolving Professional Roles and Relationships*

In 1958 a committee from the Georgia Psychological Association came to ask my help in arranging to change the wording in proposed state legislation, which used the term "psychiatric illness" instead of "mental illness." My response was that I perceived this as a generic use of the term "psychiatric." I suggested that any attempt to change the wording would place psychologists in the position of being the ones to define the word in a more narrow or restricted sense related to professional ethnocentricism, which was the very thing they wanted to avoid. I am making a similar assumption in regard to the phrase "community psychiatry" although I am well aware that there are many who would disagree. In fact, I would include in the concept of "community psychiatry" the activities of many classes of helping persons at professional, sub-professional, and common sense levels of operation. Defining distinctive role functions for any one mental health professional group is becoming increasingly difficult.

I have felt for some time that in general those of us trained in the health professions have had an orientation so heavily weighted in direction of concern for the individual organism that we have not, by and large, received sufficient basic science orientation in the other equally important aspect of man's nature. The basic concept underlying any such phrase as "social psychiatry" or "community mental health" implies an appreciation for the double nature of the human being—existence as a discreet individual organism on the one hand, and existence as a unit in many overlapping social systems on the other.

In the psychiatric training at both of our medical schools in Georgia, much emphasis is placed on the fact that for any one patient, it is not possible to predict which member of the professional team will be able to make the most meaningful contribution to the sick per-

son. It is even more difficult to accept this philosophy in regard to the distribution of functions among multiple community agencies and service programs. But the same principle obtains. It is for this reason that it is so important to consider the entire range of helping programs and professionals, such as suggested by the comprehensive outline in the diagrams from the first annual report of the joint commission.

2. *Structure and Functions of Social Systems*

It has been impressive, in working with community groups interested in mental health, to see the range of problems which arise when we fail to make an appropriate distinction between two different types of involvement. Arbitrarily, we can think of involvement on the basis of responsibility (those now involved in providing what services are provided at the community level), in contrast to involvement based upon interest without responsibility. It is startling to me to see how few people show any regard or appreciation for the roots of authority which stand behind any particular organized effort. It is even difficult to have a group keep clearly in mind the distinction between existing authoritative bodies who have the power to make decisions regarding program policies and budgets, in contrast to hypothetical groups which might someday come into existance. I am sure our state is not alone in dealing with this difficult problem.

As we attempt to assist local health departments develop new mental health programs, we urge them to base their plan, which they must submit for approval, on a factual appraisal of existing community mental health needs and resources in their community. This kind of study of the existing situation is an ambitious undertaking, and also it is equally important for other agencies such as schools, welfare, correctional, probation, religious, and other types of autonomous agencies now functioning within the community. For years we have been aware of the need for a clearer description of the existing structure and function of various groups which presume to speak for community-wide interests. I have felt for some time the need for periodic conferences which would take up the existing facts about

the structure and functions of community planning groups and discuss them against the background of the horizons of our knowledge in the field of the social sciences. This would be similar to a clinical pathological conference in which a case of illness is discussed, not so much for the benefit of the patient, as for the enlightenment and broader understanding of those participating in the discussion. A more thorough understanding of the structure and functions of social systems, particularly those representing organized helping efforts at the community level, is of vital importance. In fact, it may be equally as important as the understanding of the normal or pathological structure and function of the individual person.

3. *Limits of the Specialization Route to Excellence*

It is helpful to think of two kinds of specialized effort. One depends on possessing special skills or understandings. The other is simply a matter of intensity of effort, devoted to one particular thing. With both types of specializations, we have questions regarding the dilemma of a balance between specialized as compared with generalized functions. Or we have problems related to centering one kind of function in one type of organization, rather than in many. For example, the demand to get the mentally ill people out of jails and into the hospitals, has not been accompanied by another appropriate demand that custodial institutions provide adequate medical services, including psychiatric services for the persons who will continue to be there. The shortages of manpower, and the urge to centralize similar services in single administrative units, have led to some confusion in recommendations. We use the word "state" as though this could be a singular noun. It cannot. Any state has multiple programs which are interrelated in some kind of dynamic equilibrium. Specialization of function can be carried so far that it becomes detrimental rather than helpful. This is true not only in administrative programs, but it is also true in the professional specialties.

It is well to remember that we reach a point of diminishing returns in the development of specialized

functions in our society. We are at a point where it has become increasingly clear that one very important responsibility of the specialist is to help every person increase his capacity for doing himself the things which the specialized effort has revealed as important. This is in contrast to another important force, which works in the direction of insisting on more and more monopolistic attitudes in relation to practices by specialized personnel. It is a little confusing sometimes that we have to support both these forces, despite the fact that they work in opposite directions. In regard to mental health specialities, it is important to recognize the differences between those specialties which derive their content from experiences available to all persons, in contrast to those based on observations accessible to only a chosen few. For example, contrast the opportunities for observing the basic material from which bacteriology or nuclear physics develops as a specialty, in contrast to specialties in human behavior. Every person lives all his life in a laboratory of human behavior and human relationships. It is, therefore, quite logical that a major portion of the specialist's task in any of the mental health professions has to do with reinforcing the activities of people who are not specialists. This applies not only in individual relationships, but in program relationships. A major portion of the entire mental health program of a state should be devoted to what we might call "community resource reinforcement."

Another way of putting this is that the medical specialty of psychiatry and related specialized professional efforts should identify themselves with the orientation of specialties like obstetrics and pediatrics. These have moved away from the area where the main task is working themselves out of a job by dealing primarily with pathology. The real job of the mental health specialist is just beginning when we get rid of the pathology. In fact, we are so concerned with pathology, that many times we mislabel as pathology behavior which is really a manifestation of growth. Placing major emphasis on growth and secondary emphasis on

pathology is not to be thought of as deserting the interests of the sick.

D. CONCEPTS OF GROWTH AS A MAJOR FRAME OF REFERENCE

1. *Avoiding Inappropriate Dependency*

We spoke at the beginning of inappropriate dependency on state institutions. We should guard against becoming so absorbed in the ways in which multiple agencies could coordinate their efforts, as to overlook opportunities for placing responsibility back on the individual and his family. Our concern for which agency should be the agency to work with a family sometimes overlooks the fact that the person should carry the major responsibility himself. A year or more ago during a discussion series with a group of community leaders in Gainesville, considerable concern was expressed concerning the load of economically dependent persons in the community. As the discussion proceeded, the proposition evolved that multiple points of inappropriate dependency exist in our culture, but we are blind to them. Until we identify them and find ways of dealing with them, they will act as springs which feed the pool of more obvious economic dependency. We will never do away with inappropriate dependency by working only at those points where it has become most flagrantly obvious. We must be concerned with helping people grow to a level of self-reliance.

If we think of the direction of growth from dependency through a level of independency to a level of interdependency, we could further subdivide this and talk about levels of (1) helpless parasitism, (2) controlled conformity, (3) self-assertion, and (4) creative mutuality. It is sometimes very difficult to distinguish between the inappropriate dependency at the level of conformity and the appropriate interdependency at a level of mature functioning. Despite the gains made in this sector of the understanding of human behavior, we have vast uncharted seas which beckon us to further adventures.

Developing more effective methods for avoiding inappropriate dependency, both as individuals and in our various group efforts, is one of the most challenging tasks related to the development of emotional well-being of total populations.

Just as an example, how can the problem of inappropriate hospitalization of older persons ever be solved until we help families learn how to develop mature relationships between parent and child? How successful are we in outgrowing parent-child relationships so as to function at a level of mature friendship which would make it more possible to live peaceably in three-generation families? Is there or is there not a direct relationship between this and the pressures on the state to meet the demands of older citizens for hospitalization at state expense?

2. *Emotional Health and Release of Creative Potential*

What we have been saying is that it is the responsibility of state government programs in assuring the optimal level of emotional well-being for its citizens. It is perfectly clear that there can never be in our society any one point of decision making. The best we can hope for is the harmonious orchestration of autonomously functioning groups and individuals. Increased effectiveness of communication, and definition of common interests, can result in more effective utilization of total resources for meeting human needs, with a minimum of waste motion.

Emotional health is impossible without both the opportunity for and the practice of human capacities for meaningful self-expression, both as individuals and in groups. The release of the creative potential is the real mental health task. The removal of pathology simply clears the ground. The constant redefining of what constitutes pathology and what constitutes the by-products of growth is one of the most fascinating aspects of the so-called mental health job.

Through all the complexities of modern living, through all the demands for services for persons who are sick or disabled, through all of the apparently overwhelming need and hopeless shortage of manpower and facilities,

one thing seems to stand out clearly. The most fundamental interest of the state, which might be expressed as a concern in community psychiatry, has to do with the release of human creative potential. This is the unending challenge. Developing more adequate concepts of growth, and utilizing these as a major frame of reference, is an inevitable trend that we are caught up in, and that will be increasingly recognized as basic to future progress.

SUMMARY

Inappropriate dependency on state mental institutions is a dramatic reminder that we are long overdue in changing the stereotype that the care and the treatment of the mentally ill is a state responsibility. Our business is achieving more appropriate balances between private and public responsibility, between state level and local level responsibilities, and among the functions and contributions of various helping professions and service programs.

The concept of "community psychiatry" is useful and valid insofar as it helps assure a higher level of emotional well-being for total population groups. State government programs represent a major, but partial and limited, method by which people assure for themselves a higher level of health. No amount of excellence in specialized professional help and facilities can replace individual responsibility. No amount of treating people after they are sick will free the group of illness. The concern must be for all people—sick and not sick. Adequate emphasis on growth and appropriate stimulation and nourishment for growth will bypass or obliterate much of what we perceive as pathology.

Avoiding inappropriate dependency and releasing creative potential in both individuals and groups is a major concern of people and states. The challenge to "community psychiatry" is to demonstrate rapid and effective progress in these processes.

BOOK REVIEWS

CUMMING, JOHN AND CUMMING, ELAINE: *Ego and Milieu*; Atherton Press, New York; 1963; 275 pp.; $7.50

Books in psychiatry rarely provide credible and concrete answers. But in their collaborated work, *Ego and Milieu*, the Drs. Cumming have spawned an exception. This remarkable volume, whose sub-title is "Theory and Practice of Environmental Therapy," provides theory-knitting correlates between depth (id) psychology and ego-psychology alternating with anxiety-reducing mandates for meaningful management of individual patients and groups in hospital ward situations.

Perhaps it required a team such as psychiatrist John Cumming and sociologist Elaine Cumming to produce a behavioral science textbook so refreshingly free of dogmatics and polemics as is this one. *Ego and Milieu* is an eminently practical book built upon a faithful psychoanalytic ground floor and illuminated by the accumulated wisdom of ego-psychology. In an early chapter entitled "Some Usable Concepts of Ego in the Milieu", the Cummings acknowledge their theoretical indebtedness to Heinz Hartmann (conflict-free portion of the ego), Erik Erikson (ego identity), George Herbert Mead (the generalized other), Talcott Parsons (socialization), Kurt Lewin (growth in life space), and Paul Federn (ego feeling). However, in succeeding chapters, the Cummings show themselves to be innovators as well as integrators. They set as their task in this book the answering of an urgent question: "How can we deploy the resources of the healing and helping arts so that those who need treatment will be able to get it under conditions commensurate with that human dignity with which every person is expected to be equally credited?" Toward the practical realization of an answer, the Cummings bring their own theory of human behavior and psychological treatment, claiming for it "a traditional biosocial basis, embracing assumed neuro-physiological substrata, congenital temperament, emerging biological states, development crises, and the interactional aspects of personality." They explicitly contend not only that individual insight-producing psychotherapy is inappropriate for the restoration of ego-damaged patients, but that it is inimical to its most expeditious achievement. Citing data from their two-year research stint at the Kansas City Receiving Center, the Cummings say, "We found that the

amount of psychotherapy that could be done seemed to accomplish little beyond extending the length of stay of a selected group of patients. The decision to limit hospital treatment to milieu and physical therapies, and to offer psychotherapy upon discharge when it seemed indicated, resulted in a reduced length of stay from about thirty-seven to about twenty-seven days and a more manageable ward situation." The authors contrast individual psychotherapy, which aims for "basic" intrapsychic change and derivative social improvement, with their milieu therapy which aims for primary social change with the expectation of derivative ego growth.

Training of psychiatric residents in large mental hospitals and coherent staff treatment planning in these institutions are both hampered by a lamentable lack of consonance between the theoretical fabric (academics) and the managing of patients (logistics). As a result there is frequently little application of theory (therapeutics). Paradoxically, the split between theory and practice is often sharpest in the more progressive of the large mental hospitals. This is due undoubtedly to the historical circumstances which find academic curricula, which are predominantly psychoanalytic, being brought to bear upon institutions which are custodial. The consequences are confusion of training goals for the resident and confusion of treatment plans for the staff. In many large mental hospitals where psychiatric residents are trained the individual resident is tempted by indirection to make an "either-or" choice between mastering the techniques of psychoanalytically- inclined psychotherapy and learning the most efficient methods of manipulative treatment on the ward.

A serious reading of *Ego and Milieu* will do much to disabuse the resident of the unhappy notion that he must make an excluding choice between an intra-psychic focus and a trans-social focus. The authors very forcefully draw on Hartmann's idea that the two "portions" of the ego—the conflict-born (synthetic) and the conflict-free (executive) are interdependent. They comment, "If the synthetic function of the ego is not developing well and thus the id impulses are not under good control, the executive function has difficulty emerging. It is a truism that if a child has developed an inappropriately punitive superego, he may not be able to learn so well or so much as he would be able to if he did not have this source of guilt and anxiety, and, as a result, he will

not fully realize his complement of inherent skills. In this way, a hampered or weak synthetic function results in an improperly developed executive function, and thus the integrity of the ego must be viewed holistically. What has not been so clearly recognized in the past is that the well-being of the ego is also affected in a reverse way. If a child has learned a wide variety of skills he has an armamentarium of practical problem-solving devices which will strengthen his *executive function* and thus provide a variety of possible solutions to the conflicts with which the *synthetic function* must deal. The ego can be looked upon as a unitary structure functioning not only to placate imperious biological drives and inescapable social demands but also to invent patterns of intrinsically rewarding action."

Having defined the ego in a utilitarian fashion, the authors propose a dynamic assay of actual ego and potential ego which seems more specific and more useful than the traditional estimate of ego-strength.

The first section of the tripartite volume concludes with a highly readable cataloguing of the normative characteristics of mental patients and of the characteristics of the general human milieu.

The second section is entitled "The Structure of the Milieu" and it deals with the specifics of average milieu in mental hospitals. Many of the Cummings' observations about physical setting, authority and control, roles and relationships, and communication in mental hospitals are quite similar to those previously reported in sociological studies (e.g. Goffman's "Asylums"), but once again this volume is distinguished by a tolerant lack of caricature and condescension; it views quite seriously and sympathetically the problems inherent in the personnel structure of mental hospitals. Tolerance is not confused with complacency in the Cummings' minds, however, as they proceed with very specific and far-reaching recommendations for revision of the roles of medical director (superintendent), staff doctors, nurses, aides, and patients. One bold statement in this section asserts, "The task of developing the therapeutic milieu is largely to exploit the central role of the *nurse* to the utmost."

Part III carries the title "Ego *in* Milieu", logically combining the insights developed in the first two sections. Here is the core of the Cumming approach to the ego-reparative

treatment of substantially ego-damaged patients in the hospital.

One of the more rewarding sub-sections in this practicum is one dealing with *work*. It is possible for a trainee in contemporary mental hospitals to complete his residency with little or no understanding of the psychodynamics of work. The lucid exposition of work as human behavior in psychological and sociological aspects would alone render the Cumming book invaluable for psychiatric residents and hospital staffs.

In summary, the volume *Ego and Milieu* offers for the psychiatric trainee a concise and simple exposition of ego-psychology as applicable to restoration of hospitalized mental patients. It offers him furthermore what it purports to offer patients; namely, expanded skills in managing roles and tasks assigned by life. The book offers to the hospital director and his staff a challenge which is, however, couched more softly as an invitation to render hospital treatment more realistic and less rigid.

If the review sounds more promotional than critical, it is so by design. The reviewer judges that a considerable service would be rendered by a wholesale reading of *Ego and Milieu* among psychiatric residents and mental hospital personnel.

ARLOW, J. A. and BREENER, C. *Psychoanalytic Concepts and the Structural Theory*. J. A. P. A. Monograph Series #3, Int. Univ. Press, Inc., N. Y. 1964

This very welcome monograph is a lucid and excellent exposition of an area that has long been confusing, especially to students of analysis and non-analytic psychiatrists. Its purpose is to demonstrate the inconsistencies between the "topographic" and "structural" points of view, that is, between the concepts of unconscious, preconscious and conscious "regions" of the mind and the later divisions Freud proposed into Id, Ego and Superego.

The topographic theory ran aground with Freud's recognition of the central importance of conflict and the genesis of anxiety. Conflicts between instinctual wishes and equally unconscious anti-instinctual elements of the ego or superego would not fit into the theory. Anxiety results not necessarily from the threatening emergence of instinctual wishes into consciousness (failure of repression), but from any inability of the individual's integrative capacity to resolve the con-

flicting demands of instinctual wishes, anti-instinctual forces and external reality. Defenses may be used which do not completely bar instinctual derivatives from consciousness (e.g. denial, projection, isolation).

The authors elaborate on these objections (originally Freud's own) to the topographic theory, but in addition contribute discussions of "unconscious" fantasy, primary and secondary processes, regression, dreams and psychosis from the point of view of both theories. In the chapter on dreams the authors point out that they favor the abandonment of Freud's hypothesis of the retrogressive flow of energy during sleep, from the Preconscious (motor end of the mental apparatus) to the Unconscious (perceptual end) resulting in the hallucinated dream. Instead, dreaming consists of a fluctuating state of regressive ego and superego functioning which is quantitatively, not qualitatively, distinct from waking thought. "Primary" and "secondary process" thinking are not distinct but opposite ends of a continuum determined by the degree of regression of the ego functions of reality testing.

While the chapters on dreaming and psychosis seem to add little to current theories in these areas, this does not detract from the main thesis of the book, which is contained in the first few chapters. This is that clinical observations should not be formulated according to one theory or the other, whichever is convenient at the moment, since the two are logically incompatible and the preponderance of actual observations is on the side of the structural theory.

R. F. Spencer

NEWS BRIEFS

THE MEDICAL SOCIETY OF THE STATE OF NORTH CAROLINA

Subcommittee on Medicine and Religion

Two recent programs were held at North Carolina medical meetings on the topic of Medicine and Religion. Arne E. Larson, Assistant Director of the Department of Medicine and Religion, American Medical Association, spoke to the Tri-State Medical Association at Nags Head in June.

Mr. Larson said the purpose of the Medicine and Religion program is to create the proper climate for communication between the physician and the clergyman that will lead to the most effective care and treatment of the patient.

Hertford County Medical Society was host to the local ministerial group at a program on medicine and religion in June. Edward T. Viser, M.D., was in charge of the program.

Participating on a panel discussion were Rev. Fred W. Reid, Jr., Chaplain, N. C. Memorial Hospital; Rev. Kimsey King; Rev. Isaac Terrell; Archie Y. Eagle, M.D.; and John C. Blanton, administrator, Roanoke-Chowan Hospital. Charles A. Hubbard, Department of Medicine and Religion, AMA, was panel moderator.

Committee on Mental Health

George W. Paschal, M.D., President, Medical Society of the State of North Carolina, has recently appointed John L. McCain, M.D., Wilson, North Carolina to serve as chairman of the Medical Society's Committee on Mental Health. Dr. McCain has served as chairman of this committee since 1963.

Subcommittees of the mental health committee with appointed chairmen are: Mental Health Education, Charles R. Vernon, M.D., chairman; Mental Retardation and Children's Services, Lloyd J. Thompson, M.D., chairman; Alcoholism, H. W. Stevens, M.D., chairman; Medicine and Religion, chairman to be appointed.

All subcommittees plan to meet this summer and the parent committee will meet in Pinehurst in the fall during the Medical Society's Conclave of Committees, September 23-26, 1965.

THE NORTH CAROLINA ASSOCIATION OF MENTAL HEALTH

1965 Staff Training Institute:

Three representatives of the North Carolina Mental Health Association attended the 1965 Annual Staff Training Institute held at Swampscott, Massachusetts, June 28-July 2nd. The theme of the Institute was the Mental Health Association and Vocational Rehabilitation. Leston L. Havens, M.D., psychiatrist with the Harvard School of Medicine, served as dean for the conference.

Major attention was given to joint projects for training, counseling and rehabilitation of the mentally handicapped through the cooperation of the voluntary and public agencies with Vocational Rehabilitation.

It was noted that the vocational rehabilitation agency has increased its budget so that more assistance might now be given to the mentally and emotionally handicapped, as well as the physically handicapped.

Workshop groups exchanged program ideas and projects and made recommendations for closer relationships between the two interest groups for future benefits.

North Carolina was represented by Mrs. J. B. Spilman, executive director; Mrs. M. P. Bailey, executive secretary for Pitt County and Annette S. Boutwell, program director for the southeastern region.

Some 215 people attended the week-long institute representing both mental health associations and vocational rehabilitation agencies.

Quarterly Board Meeting Held June 24, 1965

The second quarterly board meeting for the N. C. Mental Health Association was held in Raleigh on Thursday, June 24, 1965. Committee workshops were held to determine present and future goals, following the General Board of Directors' morning meeting. Reports from key committees were given with legislation and education receiving special attention. Mrs. Heman Clark, president of the state association, presided over the day-long meeting.

The 60 representatives expressed concern over the "lack" of funds for mental health resulting from the 1965 General Assembly; however, mistakes were recognized and positive

steps were outlined for continuous community education in the support of local services. Mrs. John B. Chase of Wayne County was reappointed as chairman of the Legislative Committee for the State Association. She was commended for her work in the General Assembly in 1963 and again in 1965.

The president stated, "Present and future concerns of the State Association are and will be to continue to build community interest and participation in treatment and rehabilitation of the mentally ill patients. Professional training workshops are helping to extend the "hands" of agency personnel so that more patients may receive needed services within the home community, rather than hospitals. The state and local mental health associations will help to interpret the redistricting, the integration, and the "unit" system of state hospital treatment to the public. Through local educational programs, it is hoped that these changes can be made with the least difficulty and maximum cooperation for patients and families. More and more volunteer service workers will be needed in the community, therefore local associations are taking major steps to expedite this effort. With more attention being given to the "comprehensive" care of patients, local associations stand ready to assist clinic and hospital staff in creating necessary community action to facilitate the construction and staffing of the new facilities. Leaders of the mental health associations can and will assist with the job necessary for needed support within the next two years."

Community Programs:

Wilson County Mental Health Association has just completed three long-term workshops. One was for ministers, a second for nurses, and a third was for leadership of the community concerning the problems of delinquency.

Lee County Mental Health Association will sponsor four weekly workshop sessions for nurses in August. Speakers will be Dr. Norbert L. Kelly, director of the education division, N. C. State Department of Mental Health; Dr. Assadullah Meymandi-Nejad, resident in psychiatry, Dorothea Dix Hospital; and Dr. A. R. Mayberry, Lee County Mental Health Clinic director.

Plant are being made for a series of industrial relations seminars in eastern North Carolina counties for late Septem-

ber. Dr. Edward L. Fleming, psychologist from Florida, will be the principal speaker.

Several of the local mental health associations awarded summer training scholarships for teachers to obtain further advance study in subjects related to the mental health field. Education being the primary function of local associations, each county is encouraged to participate in scholarship sponsorship.

The State Mental Health Association, through its Education Committee, is sponsoring a two-day workshop for local executive secretaries and education committee chairman in Southern Pines, October 7 and 8. Dr. Norbert L. Kelly will be one of the principal speakers.

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NORTH CAROLINA

JOURNAL OF MENTAL HEALTH

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This journal is intended to be inclusive rather than exclusive and is not meant to be regarded as simply a house organ of the North Carolina State Department of Mental Health.

It is hoped that the journal will reflect the broad-based philosophy of psychiatry current and will draw on areas reflecting the total spectrum of psychiatric and neurologic thought, program and research.

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(Notice to contributors — see inner back cover)

NORTH CAROLINA JOURNAL OF
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EDITORIAL

The Unexamined Life is Not Worth Living

The title is a quotation more than two thousand years old and attributed to Socrates. Time has certainly not worn his comment thin but rather has proven it to be more significant. In these times of constant change and increased activity it behooves us all to pay particular attention to such a statement. In psychiatry and mental health there is need for constant self-awareness, self-evaluation, and goal-setting. Moreover, there is a need for the same kind of process not only in terms of self but also in terms of programs in which we are involved. There is need for increased activity and many times for change; it is important, however, that these not deteriorate into "busy work." We must more than ever effect methods of program awareness, program evaluation, program planning, and goal setting and then a constant reappraisal of goals set.

Psychiatry is beset by clichés and fads. All too easily these are accepted or rejected, depending on popular reaction. The changes, increased activities, clichés, and fads exist within a framework of people and inter-personal reactions whose evolution proceeds slowly, encumbered but also enhanced by the summation of experience. Whether any of us and any programs we are involved in are enhanced or encumbered by our experiences is largely dependent on our examination of them.

N. E. Stratas, M.D.

Some Practical Considerations About Group Therapy

Fred Thompson, M.D.
Raleigh, North Carolina

The aim of this paper will be to present some of the practical problems one encounters in group therapy work with special emphasis on the difficulties encountered by those beginning with group work. Since its origin in the early 1900s, group therapy has been a tool of constantly increasing importance in the therapeutic armamentarium. There are several reasons why it is important that all those being trained in the mental health fields should know group therapy. First, and perhaps foremost, this is a very effective therapeutic tool. There are some types of patients who are handled much more efficiently with group therapy than with individual and/or somatic therapies. Examples of this would be some intensely dependent patients or those who would fall in the passive-aggressive category. Secondly, with increased emphasis on community mental health, group therapy is becoming more important because of its efficiency. It is efficient in two ways —both as to time and finances. One therapist can treat many times the number of patients in a group than with individual therapy. Also, patients are more able to afford group therapy than individual therapy. Finally, considerable attention has been given group therapy through the mass media of magazines, television, etc. The public is becoming increasingly aware of it and often expects the worker in mental health to know and practice it. There are many types of group therapy (supportive, analysis, psychodrama, etc.). This paper is concerned with that type which has variously been called psychoanalytically oriented, intensive, etc. It corresponds most closely to once-a-week, long-term, psychoanalytically oriented individual therapy.

In discussing some of the problems in therapy with groups I find it useful to break the group process into four stages. Stage one represents preparation and evaluation of the prospective members for the group prior to the first meeting of the group. Stage two represents the period from the initial session through the formation of group cohesiveness. This usually lasts from five to ten sessions. Stage three represents

the working-through phase and will last a varying amount of time according to how long the group runs. Stage four is the termination phase and should last five to ten sessions. Definitions of each of these phases will be given in the discussion of each. My experience has been that the beginning therapist seems to experience the greatest difficulty in stage two. My feeling is that by handling stage one carefully many of the problems in stage two can be avoided. The bulk of this paper will be spent in consideration of these two stages because they determine what will follow later in therapy.

Many people are inclined to bypass stage one and start by locating some six to ten people and telling them to come for group. I feel this is where difficulties with dropouts, hostility, querulousness, therapist anxiety, etc., originate. This stage is defined as the period from the start of therapy until group cohesiveness is established. There have been many definitions of cohesiveness. I am using this term to mean that period in which the members of the group develop relatedness to each other and cease to visualize the group meetings as a "class" with the therapist as "teacher." In my opinion the most beneficial results in group therapy are a result of the patients' interactions as opposed to therapist-patient interactions. If the group is brought together without previous preparation, two serious pitfalls loom. First, the group may become insecure, anxious and uneasy resulting in group hostility and multiple dropouts. Second, the therapist becomes uneasy with the unstructured system and establishes an authoritarian "teacher-pupil" relationship with the group. Either of these problems can be managed but a lot of unnecessary difficulty is entailed. Again, good preparation in stage one will alleviate most of this difficulty. More will follow on this after a consideration of stage one.

STAGE I PREPARING THE GROUP

The first step in preparing the group is conceptual on the part of the therapist. In this step the therapist plans the group. Six variables should be considered:

(1) *NUMBER*—Most authorities feel that six to ten members are an optimal number for a group. In planning the size of the group, one must avoid two things. If the group is too small there will not be enough patient-to-patient interaction. If the group is too large the

more passive members are likely to either get pushed aside or to "hide" defensively in the large size of the group. One must also bear in mind that there will often be one to two patients absent. I have found that five or seven patients are the most workable number to have in a given session. There are practical limitations which must be considered. For example, the size of the room may limit the number. I start with seven patients as a compromise figure. If there are one or two absent this still gives me a fairly workable group; and yet, if all are present the group is not too large.

(2) *SEX*—The sex of the group can be handled almost any way—all-male, all-female, or mixed. It had been reported that the least group activity occurs in all-female groups with all-male groups next and mixed groups showing the most activity. This, of course, will vary according to the type of patients in the group, the therapist's skill, etc. I have found mixed groups to be the most active.

(3) *DIAGNOSIS*—There have been reports of almost any diagnostic entity being treated successfully in groups. I feel, however, there are rules of thumb. First, don't mix neurotics and psychotics. This cannot be an absolute rule as one will find that some borderline patients will fit in fairly well with a neurotic group. A second rule is to avoid homogeneity. That is, avoid putting patients who are close to being alike in terms of character structure, situation, etc., in the same group. Again, this isn't necessarily true and there have been numerous reports of successful groups composed entirely of homosexuals, asthmatics, alcoholics, etc. I have had success in mixing the groups because I feel that different personality types have more that is new to offer each other.

(4) *HOMOGENEOUS VERSUS HETEROGENEOUS*—This question is really an extension of the one above. There is one rule of thumb here. Do not put any one or two persons in a group who will clearly form a subgroup. Several areas should be considered:

a. SEX—Try to get a fairly evenly balanced number of males and females if you have a mixed group.

b. AGE—Don't put one person in a group who is clearly much older or younger than the rest of the group.

c. MARITAL STATUS—Again, do not put an individual who is either married or unmarried with a group who are of different marital status.

d. DIAGNOSIS—As mentioned above, psychotics probably will not do well with a neurotic group. Sexual deviates often have a difficult time in being accepted into a group. Many people feel that sociopaths will be disruptive.

e. IQ, SOCIOECONOMIC STATUS, AND EDUCATION are of lesser importance except with extreme deviation from the rest of the group. Certainly any of these distinctions need not be rigid and one finds that they can "get away" with quite a bit in this area if it is necessary.

(5) *TIME AND PLACE*—The therapist must decide and be fairly firm as to when the group will meet. If the patients are motivated they will get there. If they demand special times, etc., this often will set up a difficult permissiveness with the group and the therapist will not be respected. I have found it helpful to have group at off hours, such as over a noon hour or the last hour in the working day. Some people have their groups in the evening and this seems to work very well. Comfortable chairs in a circular arrangement work best.

(6) *FEE*—The fee may be set according to one's own wishes. Our private fees are $10.00 for 90 minutes. This has been criticized by others as both being too high and too low. Unless you are in a clinic setting, I feel it is best to charge everyone the same amount. One should make a set rule on nonattendance payments. Our rule is that the person will give 24 hours notice or be charged for a missed interview unless an emergency has arisen.

(7) *DURATION OF THE GROUP MEETINGS*—The therapist should decide whether his group be closed or open ended. By this I mean whether he will run the group indefinitely, adding new members as he termi-

nates others, or whether he will place a time limit on the group. One compromise measure is to leave the group open ended at the start and make a decision with the group later as to when to terminate.

(8) *OPEN OR CLOSED GROUP AS TO NEW MEMBERS*—One should decide whether to keep the composition of the group constant, using only the members who start, or whether members will be added from time to time. Obviously an open ended group must be open to new members. A closed ended group may exclude new members. This will, however, cause problems when members drop out of the group, as is often the case. My solution to this problem is to keep the group closed except for replacing dropouts. I then discuss proposed new members with the group and let them make a decision as to whether the new member is acceptable.

The second preparatory step is the selection of the group. I believe the following to be helpful:

(1) Work up patients yourself. Get a good understanding of the background, dynamics and personality patterns of each patient in the group.

(2) See the patients enough so that they get some concept of their intrapsychic difficulties and the areas they may most profitably work on in the group.

(3) If a patient has to wait for an opening in group, he should be seen at regular intervals in the interim.

(4) Do not put an individual in the group until he is fairly comfortable in expressing himself in your presence.

The third step is preparing the group members. There are three main areas:

(1) *MOTIVATING*—Probably no one is really motivated for group therapy. If someone comes in asking for group therapy and hasn't previously been in group it is best to explore why they want group. Often it will be found this is a defense against openly discussing their problems or is based on unrealistic expectations. It is useful to discuss both the purpose and goals of group therapy with the patient. I often do this in terms of an analogy wherein the group is like a lab wherein there exists a safe environment for learning about and

experimenting with feelings. By this time, of course, I have gone over the relation between feelings and symptoms with the patient.

(2) *POINTS TO BE GONE OVER WITH EACH MEMBER*

a. The names of the other members in the group.
b. The time and place of group meeting.
c. The duration of each meeting.
d. Whether it is an open ended or closed ended group.
e. The need for regular attendance.
f. A rule for attending the group for at least five meetings and paying for five meetings whether they drop out or not. This rule is very useful in helping patients to get over the initial hump in group therapy. It has been found that a large percentage of dropouts occur within the first five sessions.
g. Rules for addition of new members.
h. The need for confidentiality both on the part of the patients and the therapist.
i. Fees, mode of payment and charges for missed meetings. It is helpful to have a rule that delinquent bills will be brought up in the regular meetings.
j. Rules about phone calls to the therapist should be stated. I always find it helpful to tell the patient they may call me if they wish but that they must recognize that I will bring this material up for consideration in the group.
k. Rules for extra individual sessions and the charge for them should be made. I encourage the group members to request an extra session if they have material they feel they cannot discuss in the group, or if they feel they are "stuck" in their work within the group. I charge them the regular individual fee.
l. Outside contacts with the members of the group should be avoided. They should be reported in the regular setting if they occur.
m. Instructions about special circumstances should be included, such as observers one might have or use of tape recorded material for supervision or teaching.
n. I use first names in my group and tell the patients about this initially.

o. I usually issue some warning that in the beginning a group will go slowly until the patients get to know each other.

p. I tell the patients that they are to express whatever feelings they have verbally but are not to act them out in the group setting.

(3) *INSTRUCTIONS FOR STARTING*—Several instructions should be offered about the beginning sessions.

a. I tell the patient that the first group meeting will be opened with each person introducing himself and telling what he would like about himself and his problems. I point out that the more they can say about themselves the better.

b. I encourage them to ask the other patients questions in the introduction and make whatever personal comparisons they can.

c. I encourage them to express whatever feelings they have about the other members of the group and about the therapist.

d. I tell them that I will initially be quite passive and will say very little. I explain that this is to allow the group members to get to know each other and to learn to communicate with each other. I point out that the more the therapist talks in the early phases of therapy the less the patients will interact and ultimately the less they will get out of therapy.

Two other problems are relevant. The first is that of recording the sessions. If one is to pay close enough attention to do good group therapy it is quite impossible to take notes. However, some record of the group should be kept for three reasons:

(1) For supervision.
(2) For one's own edification—to check trends, etc.
(3) For teaching purposes.

I have experimented with three methods of record-keeping. The first is to make notes after the session is over. These can either be handwritten or, if such is available, dictated. The only problem is that it takes extra time and if one is operating on a tight schedule there may be a tendency not to do it. The second method involves the use of a tape recorder. A great deal of time is required to listen to and edit the tape so that

it will be useful for supervision, etc. The third method is to use a human recorder. If such a person can be obtained this certainly is the best method because there is an objective observer of both the verbal and nonverbal material. Often someone in training will be willing to participate as a recorder. I have found this method to be most beneficial both to the recorder and to the therapist.

STAGE II FORMATION OF GROUP COHESIVENESS

When the group is ready to start I ask them to come to the therapy room. I make a few remarks to the effect that the rules have been discussed with each patient individually, and if there are questions about these they can be brought up later. I suggest that they start by introducing themselves and telling about the problems they have had. I start around the room going either clockwise or counter-clockwise. I try to pick someone who talks fairly comfortably as the first patient to introduce himself. If one starts with a patient who is very anxious this will increase the group anxiety considerably and has a tendency to get things off to a bad start. I invite the members to question, comment and make comparisons. If the introduction goes around without much discussion I make a summary and ask the group how they felt about some of the other people's problems. The main thing that one must try to do in this stage is avoid one-to-one, patient-therapist, question-and-answer communications. One technique that I have found useful is to avoid eye-to-eye contact with any patient who is speaking. This will force the patient into addressing the other members rather than the therapist.

Stage II will continue for several sessions and a number of trends will be noticed. First, one will note increasing member-to-member communication and decreasing member-to-therapist communication. A good rule of thumb as to when the group is entering the second phase is that the patients address communications almost exclusively toward other patients and seldom or never toward the therapist. Second, one will notice the formation of a co-therapist or co-therapists with power struggles between them. Third, there will usually be anger at the therapist for not giving answers and behaving as an authority figure. Fourth, some members will display a tendency to withdraw. Almost without exception the group

will eventually become hostile toward the withdrawn member. Fifth, one sees the early formation of transferences in this phase.

STAGE III WORKING PHASE

Most books on group therapy are concerned largely with this stage. My intent here is to point out only a few of the trends and pitfalls in this area without attempting to give a complete resume of all the types of interaction that go on.

The main goals of this stage are:

(1) To help the members learn to ventilate feeling in an acceptable, non-self-defeating manner.
(2) To become aware of their own maladaptive interpersonal behavior, using the other members as a mirror.
(3) To learn the relation of symptoms to attitudes and response patterns.

Several trends are seen as the working phase develops:

(1) The members begin to relate to each other instead of the therapist. Only when you feel quite certain that this has taken place should you begin to be more active.
(2) Along with the development of this group relatedness there is abdication of the therapist as an authority figure. Usually there will be considerable unexpressed anger about this. Various members of the group will attempt to lead the group and assume the role of co-therapist. Invariably they evoke the wrath of the other members of the group. This often can be quite fierce. The therapist must recognize that this anger is largely displaced from himself. The following interpretations can be made:
    a. The group is really not so much angry at the "co-therapist" for attempting to lead as they are at the therapist for not satisfying their fantasied need for an omnipotent parent-like figure who will present them with magical solutions to their difficulties.
    b. The group has a need to depend on a strong parent figure.
    c. The co-therapist has a need to dominate and control and this may serve as a defense.
(3) As the meetings progress, there is less and less focus on symptoms and more focus on actual problems in

living. The members of the group begin to take an active interest in the other members of the group and their lives. Many types of relatedness will develop:

a. *Formation of transferences.* The most common types here seem to be husband-wife, parent-child, sibling-sibling.
b. *Identifications.* Symptom exchange is not infrequent.
c. *Expression of Anger.* Displacement is usually one of the main mechanisms. There will be much jealousy over improvement in the various members.
d. In addition to the expression of negative effect one will also find considerable *expression of positive feeling.* Groups have a tremendous ability to be supportive to individual members. Often groups have difficulty in verbalizing positive feeling and will need support and interpretation from the therapist.

(4) As the therapist becomes increasingly sure of the group cohesiveness and relatedness he can begin to participate more. My feeling is that individual interpretations should be kept fairly minimal. I use five basic types of interpretation:

a. Pointing out interpersonal processes.
b. Pointing out group trends.
c. Making comparisons between members.
d. Generalizing individual attitudes or feelings.
e. Summarizing.

An occasional individual interpretation is probably irresistible and may even be helpful. The literature over-emphasizes avoidance of the individual interpretation; however, the point needs to be stressed because the therapist who is oriented toward individual work will have a tendency to make excessive individual interpretations. This will rapidly cause the group to break down into multiple one-to-one pupil-teacher relationships.

A very occasional counter-transference interpretation may be helpful, especially if you are angry with a particular patient. Be careful to fully understand your feeling and the dynamics of it before you make such an interpretation. Do not do this too much. Occasionally the group can be used to

help with a particular problem the therapist is having with one of the individual members of the group.

Several problems are encountered in phase three:

(1) *GROUP RESISTANCE*—This will often manifest itself in silence or talking about very superficial subjects. The therapist usually deals with this by identifying it and exploring the reasons for it. If this does not work, some therapists feel that warmups of various types are helpful. This includes such techniques as going around the room and asking the group members to tell about their experiences of the previous week, or to state what they feel the problems are in the group, etc. This is probably a technique which should be used sparingly because it involves considerable directiveness on the part of the therapist.

(2) *DROPOUTS*—There will be dropouts for both practical and psychological reasons no matter what you do. If a member talks about dropping out I try to get him to discuss this fully in the group situation. I make such statements as, "How do you all feel about Mr. X quitting?", or "I imagine others of you have felt this way," or "Often at this stage in therapy members will want to quit because they become uneasy about something," etc. In spite of what one does an occasional member will be lost. This will necessitate the addition of a new member to the group. I always make it a point to bring up the new member's name, age, marital status and something about his problem with the group. If this is the first new member to be added I caution the group that it may slow the group down a bit initially. I also try to give the new member some summary as to what has gone on in the group and to warn him that it may take him some time to fully integrate himself into the group.

(3) *ACTING-OUT*—This usually occurs in the areas of either sexuality or breaking various of the group rules. I feel that the best technique in preventing this is that which I outlined in Stage I—good preparation before the group starts. If acting-out occurs in spite of this, one can bring it before the group and use group pressure to control it. An individual session is sometimes

helpful in getting the individual member to understand why he is using this mechanism. If all else fails, it is occasionally necessary to set firm limits and demand that the acting-out member either conform to the group rules or leave the group.

(4) *COUNTER-TRANSFERENCE*—The group can generate tremendous negative and positive feelings in the therapist. Frequently when the group meetings move slowly the therapist will find himself discouraged and angry with the group. The techniques for controlling this are supervision, self-understanding, and perhaps an occasional counter-transference interpretation as discussed above.

(5) *AWARENESS*—One often hears the comment from those who either are beginning with group work or who have had no experience in group work that one has enough trouble knowing what is going on with one patient, and with seven there are far too many variables. I certainly agree there are a lot. My suggestions are:

a. Don't let this keep you away from group work.
b. Be as aware as you can of everything that is going on. Consider all verbalizations, interactions, and behavior as potentially useful data.
c. Don't expect yourself to be omnipotent. Admit that you do not know and cannot know everything that is going on in the group. Try to learn as much as you can from the group.
d. Experience and supervision will increase one's awareness tremendously.

(6) *MISSED SESSIONS BY THE THERAPIST*—Try not to miss many consecutive sessions. This is especially important in stage two. Do not start a group when there are intervening holidays, etc. Consider an alternate therapist if a long absence is anticipated.

STAGE IV TERMINATION

This is obviously going to be a problem only with closed ended groups. There are several trends which will be noted when the announcement is made that a group is to be terminated.

(1) The development of anxiety and renewal of symptoms.
(2) Gradual backing off affectively from each other by the group members.
(3) Those who must continue with therapy will feel considerable anger, both at the therapist and at the terminating members.
(4) There will be considerable difficulty in expressing gratitude and positive feeling.

There are several techniques to assist with the problems found in this stage:

(1) Decide early enough on termination so that the group will have time to work through their anxiety and other feelings about it. I like to allow at least six weeks for this.
(2) If your group is meeting two or three times a week, taper it off to once a week in the termination period.
(3) Help the group to ventilate positive and negative feelings they have toward each other, toward the therapist, and toward termination.
(4) Interpret the return of symptoms as resentment and dependency.

SUMMARY AND CONCLUSION

The following points were emphasized in this paper:

(1) Everyone should try group and at least have a working knowledge of it.
(2) Good preparation in Stage I will alleviate many of the later problems.
(3) Inactivity in Stage II will set the stage for good group cohesiveness and good patient-to-patient interaction.
(4) Awareness of the ongoing group process without a need for omnipotence will make the therapist more comfortable in Stage III and will enhance the working-through process.
(5) Ample time should be allowed for termination in Stage IV.

Group Therapy and Supportive Treatment with the Passive-Dependent Patient of Low Mentality

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Much has been said and quite a few studies have been made dealing with group treatment of neurotic patients both in supportive and analytical psychotherapy. However, little has been done or, at least to my knowledge, little written about group work with the passive-dependent patient of low mentality who comes to the outpatient mental health clinic for help with his problems. Perhaps group treatment with this particular type of patient is unique in that in this geographical area there seem to be many such patients who are referred to the clinics for help or who themselves seek treatment. It seems to me that as therapists we have an obligation to the community we serve to offer whatever help is available to all people and that our program of service should be structured to meet the needs of all community members.

This paper has been prepared with the thought that perhaps some contribution can be made to the concept of supportive group work with patients in this particular category. As President Johnson has expressed in his overall anti-poverty program for the "Great Society," much needs to be done for all the people, and it is not surprising to note that these patients constitute a fairly high percentage of our society, more often than not representing the low income group on the "financial fringe" of the poverty area. We are in possession of facts and statistics which prove sociologically that in the American culture there is a high correlation between education, occupation, and income. The status and role of such a patient as we describe are often predetermined. However, we can help to alter the role behavior of such an individual and in some instances to elevate his esteem, not only of himself but among his fellowmen.[1]

We are all familiar with the neurotic patient who presents himself with many psychosomatic complaints. He is concerned with his overall inability to function, to maintain his own status quo as it were with his peers, and his failure to see himself as a "whole person." His anxiety manifests itself in a

host of bodily symptoms and in a passive manner he clings to his dependency needs which hopefully will perhaps bring some rewards of a satisfying nature. In working with patients in this category we can be supportive and attempt to work with the person either in individual therapy, group therapy, or a combination of both, whichever seems indicated.

As Gardner Murphy has pointed out in his paper, "Group Work With The Neurotic Patient," there are many facets to be considered in working with such a group;[2] the dynamics involve the benefits that these patients often seek for themselves other than through the therapeutic relationships of the group, namely those of secondary gains. To define this more in detail: The receiving of financial payments through Social Security, APTD, etc., for what is interpreted by the patient as physical disability can often result in a more stressful situation for the individual, as he may work harder to maintain his dependency in this manner. Perhaps the rationalization here indicates that he sees himself as receiving financial help because he is unable to function as a whole person. This defense mechanism is used to proclaim that he need not attempt to change things for himself because we have said that he is physically unable to do so. In essence, we have supported his need to be cared for, to look after him, and in so doing we have defeated our own purpose of what we set out to do in the beginning. Another aspect of this process is that the patient is aware that because he is considered unable to function as a contributing member of society, he has other gains made available to him which are also satisfying, and it may cause him to feel resentful if demands are made on him to give these up. Not only in the group atmosphere does he find solace, sympathy, and attention from the other group members, but he soon learns that his family, friends, and others become more understanding. Therefore, he no longer has to strive to adapt to his environment except in a helpless fashion. It is only a natural result that he grows reluctant to contemplate or see himself involved in changing his situation.

Dorothy Stock and Herbert A. Thelen in their paper, "Emotional Dynamics and Group Culture" deal with this phenomenon, citing comments from Bion's writings in which he summarizes his experiences in working with small groups of neurotic patients.[3] Bion provided no direction or structure in the group, allowing the patients' reactions to this lack of

structure to constitute the initial material for therapy. Content discussed in the group might derive from personal experiences of members or from group events, including members' feelings about the therapist or one another. The group's mood and individual reactions to the group situation were used as a basis for the therapist's interpretations, which varied, as would be expected, from one session to another.

Bion also felt that the emotional aspect of group operation with such patients could be described in terms of three comprehensively defined emotional states which he called "cultures." These he spoke of as "dependency," "pairing," and "fight-flight." The dependence is defined as if the group exists in order to find support and direction from something outside itself, pairing as if its function is to find strength from within its own peer group, and fight-flight as if its purpose is to avoid something by fighting or running away from it. The "as ifs" represented an important factor to Bion's thinking, as he interprets this to mean that if one can assume that the group is acting out as if it needs support and direction from something outside itself, then the diverse and apparently illogical and contradictory behavior of the members of the group can be understood and will take on a certain coherence and order.

Out of my own experience in working with such patients, I feel that my task here is to help each individual to work through his own needs if only to recognize how his defenses result in the effect that he presents. In such a group it is possible for the patient to find warmth and cohesion of a sort of family solidarity with which the suffering individual can identify; without any change of role the individual patient can immerse himself in and become deeply identified with other group members, experiencing the giving as well as the receiving of help. This experience, as Burrow believed, becomes a therapeutic process when the emotionally troubled person finds his distorted self-image clarified as he observes others and their reaction to him.[4] Samuel Slavson points out that the group setting provides the method by which patients, both children and adults, are encouraged to act out their conflicts and behavior problems; that the interaction of the group members is in itself a therapeutic tool; and that it is possible to change human behavior within the group structure.[5]

May I say here that in my role as therapist of a small group of neurotic patients of low mentality the concepts as outlined

in this paper have seemed to apply in part, if not in whole, in working with such a group in an outpatient clinic setting. In addition, I might add that the goals of treatment have been set within the limits of what the group could be expected to accomplish and the methods used have been purely experimental ones. No attempt has at any time been made to deal with content of any depth by analytical process or through intensive psychotherapy. Treatment has been of a supportive nature, the patients being given an opportunity to come together at a regular time for a stated period to discuss and to talk about themselves and their problems, and how they feel about them and themselves, with the therapist present to lend support and direction to the group. As Dr. Carl Binger has said, "One could say a person of borderline intelligence is seldom capable of achieving emotional maturity but even in the genius class of intelligence there are many people who have never succeeded in attaining anything even resembling emotional maturity." [6]

It has been said that to treat such a group may be a waste of time and energy, an exasperating and frustrating experience for the therapist with little or no expectancy for success. To some it may actually appear as a hopeless and futile task. I would like to comment here that for me it has been one of the most satisfying and rewarding experiences I have ever had in working with a group. It has been necessary for me to be constantly aware and cognizant of my goals for the group as well as the limits of what is to be accomplished. In doing so I can measure "success" with the group only in terms of what the group experience has meant for the patients and the opportunity it has afforded me to learn from it.

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The Dichotomy of Depressive Disorders A Literature Review

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The classification of depressive disorders into different types has been approached in a variety of manners. The most widespread system in use today is that inherited largely from Kraepelin, which has been developed by the American Psychiatric Association (1). Such kinds include psychoneurotic depressive reaction, and the psychotic reactions, that is, involutional psychotic reaction, manic-depressive reaction and psychotic depressive reaction. The fact that some depressed patients within one diagnostic category improve with certain antidepressants or with electroshock therapy whereas others do not, in addition to differences among depressives in such areas as etiology and prognosis, have made this traditional approach to diagnosis inadequate. Thus, the advent of new methods of treatment, the discoveries of physiological correlates of depression and other scientific findings necessitate a new and more sophisticated approach to the classification of depression.

THE PHENOMENOLOGY OF DEPRESSION

Attempts have recently been made to describe depression in terms of its phenomenological aspects, especially by the use of factor analysis. In an extensive study Grinker and his associates (2) analyzed standard interviews and observations made by hospital staff members. Factor analysis of these data yielded five major types of depression:

1) Patients who experienced hopelessness, a sense of failure, unworthiness, guilt and internal suffering, who felt that nothing environmental could alter their feelings;

2) Those who felt depressed about some material loss and who were convinced that change in environment could change their condition;

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3) Those who were obsessed with guilt with concomitant feelings that their condition was deserved;

4) Those whose primary symptom was free-floating anxiety; and

5) Those who were jealous of others, who gained secondary satisfaction from projecting their guilt to others.

In addition, ten behavioral characteristics were isolated, such as isolation and withdrawal and characteristics of agitation.

In a later study Friedman and his associates (3) used a 60-item rating scale to isolate symptoms, traits and themes in psychotic depressives. The 170 Ss had diagnoses of psychotic depressive reaction, manic-depression and involutional psychotic depression. Included in this study were agitated depressions and "simple endogenous depressions with retardation and with psychosomatic or 'biological signs.' " Factor analysis of their data resulted in the following types, similar to those of Grinker et al.:

1) Very depressed type filled with guilt, doubting, loss of self-esteem and tendency to internalize their problems;

2) Retarded, withdrawn, apathetic type;

3) A condition primarily manifesting psychosomatic symptoms, such as constipation, anorexia and sleep disturbances; and

4) A hypochondriacal, complaining type making excessive demands of others.

PHYSIOLOGICAL BASIS OF DEPRESSION

At the same time there has been increased interest in the consideration of physiological bases of depression in general or in certain types of depression. According to Kraines (4), the etiology of manic-depressive reactions (a concept he broadened to include all endogenous depressions) is physiological with psychological factors serving as secondary or modifying agents. Kraines argued that evidence demonstrates that the rhinencephalon is not only the "olfactory brain," but also is important in a yet undelineated way in emotion. It is the author's impression that

> the circuit from the mamillary body via the anterior thalamic nucleus to the cingular gyrus and thence widely across the cortex is involved in the elaboration of emotion, transforming the sensory elements initially integrated in the thalamus and the psychic responses of the cortex into the quality of emotion. It would therefore appear that in the Manic-Depressive Illness the rhinencephalic

> dysfunction looms large in the symptom complex, "elaborating" distorted stimuli from the diencephalon at one end and the cerebral cortex at the other (pp. 492-493).

Kraines further stated that stimuli continue to arrive at the cortex from the peripheral organs, but that integration is impaired in depression. Thus, the "diencephalic-rhinencephalic-reticular systems" are the mediating mechanisms in manic-depression (endogenous depression). Such malfunctions may stem from endocrine dysfunction, nutritional deficiency, metabolic imbalances and any other phenomena which may affect these systems (p. 516). He concluded that it is this physiological dysfunction which is responsible for the psychological manifestations of the illness. Feelings of depersonalization, distortion of reality, feelings of uneasiness and, in severe depression, feelings of intense fear could be accounted for by this mechanism. This disturbance can also account for other features of depression, e.g., disturbances in sleeping and psychosomatic symptoms. Each case of depression, however, is an individual one, for the patient's psychological response to it is dependent on his individual personality make-up.

In the same vein, Woolley (5) advanced a more specific theory, compatible with Kraines', about the etiology of depression. He hypothesized that individuals with a predisposition to psychotic depression might inherit a partial deficiency of serotonin, a substance for which he argued there is empirical evidence for its being directly involved in mental processes. Serotonin, which is found in several areas in the brain, especially in the hypothalamus and pineal gland, serves to inhibit the transmission of nerve impulses in certain anatomical areas, e.g., impulses in the optic nerves and impulses through the corpus callosum. Woolley offered some indirect evidence for the involvement of serotonin in depression, such as the fact that some analogs to serotonin can produce a reaction similar to psychotic depression (p. 16). In addition, some antidepressants (mono-amine oxidase inhibitors) increase the concentration of serotonin. It should be noted, however, that other analogs to serotonin do not produce a psychotic-like depression and that many antidepressants do not increase the production of serotonin. Woolley concluded that an individual may inherit a predisposition to depression, but such a reaction will not occur unless there are important, contributory psychological factors operating.

In addition, Roth (6) argued that there was considerable evidence suggesting that in depression the genetic predisposition is due to a simple dominant gene of reduced penetrance. Using 23 pairs of manic-depressive, monozygotic twins and 67 pairs of dizygotics, Rosanoff, Handy and Plesset (7) found the concordance for monozygotics to be 69.7 per cent; for dizygotics, only 16.4 per cent. Similarly, with 60 twins having an endogenous affective disorder, DaFonseca (8) found the concordance to be 75 per cent for monozygotics and 38.5 per cent for dizygotics. Kallman's figures for several studies include concordance rates of 26.3 and 23.6 per cent for dizygotics with 95.7 per cent and 92.6 per cent for monozygotics (9, 10).

Several other experiments have been performed concerning the physiological nature of depression. Gottlieb and Paulson (11) carried out a longitudinal study to ascertain if rate of salivary output was related to feelings of depression in patients with a primary depression. They found that depressed patients had a significantly lower rate of salivation as compared to normals. Readministration of the test upon recovery, however, showed no significant increase in salivation output in depressed individuals. The authors suggested that a low salivary output might be related to proneness to depression rather than to mood changes. These authors also investigated changes in EEG patterns of depressives from the time of hospital admission to discharge (12). Using 11 Ss, they found that in response to photic stimulation there was no change in latency of response; however, the frequency of arousal to the stimulus did increase while the average duration of the response tended to decrease at the time of discharge, as compared to admission. It was suggested that during depression the attentional threshold increases, and at the same time integration of stimuli in the central nervous system decreases.

The Funkenstein test, which involves the measurement of changes in blood pressure following adrenergic and cholinergic stimulation, has been employed to compare the response to electroshock therapy of depressives and other diagnostic groups (13-15). The results of a series of experiments demonstrated that most depressives tended to experience a high rise in blood pressure after the injection of epinephrine and a drop in blood pressure with failure to reach the pre-injection level within 25 minutes following the injection of mecholyl.

In addition, if the reaction patterns of schizophrenics were similar to the above description, they usually displayed affective symptoms. It was found that patients in this group were rated as "improved" following electroshock therapy more frequently than were those who showed different reaction patterns, with the exception of patients having a "chill" following the injection of mecholyl, who also were often rated as "improved." Electroshock therapy for the "improved" patients usually resulted in a lowering of resting blood pressure, an increase in response to epinephrine and a decrease in response to mecholyl. It was concluded that electroshock therapy increases the response of the sympathetic nervous system to stimulation while decreasing the reaction of the parasympathetic nervous system, a finding that parallels that of Gottlieb and Paulson in respect to improved depressives (12).

ENDOGENOUS AND REACTIVE DEPRESSION

One classification which is used extensively in Europe but which has received little attention in this country is the breakdown of depression into two broad categories, endogenous and reactive.[1] The concept of reactive and endogenous depression implies two fairly distinct groups of depression, in contrast to the concept that it represents a spread of symptoms along a normal distribution. One of the first to use the term "endogenous" was Kraepelin (16), who divided psychiatric disorders into two types: exogenous, which indicated acquired conditions leading to cortical malfunction, e.g., exhaustion, metabolic disease and emotional disturbance; and endogenous, which referred to congenital disturbances, such as age, sex and heredity. He believed manic-depressive reactions, paranoia, senility and mental retardation to be endogenous; and dementia praecox, paresis and alcoholic syndromes to be exogenous.

The concept of reactive depression is, of course, widely accepted in this country; however, there is dispute about the validity of the diagnostic category of endogenous depression, which implies a physiological predisposition to this condition. The following description of differential symptoms and history should help to clarify the concepts of those who advocate such a dichotomous classification of depression (4, 6, 8, 17-19).

[1] Also called psychotic and neurotic, primary and secondary, and endogenous and exogenous.

Endogenous Depression

In endogenous depressive disorders there is usually a family history of depression or "nervous breakdowns" in addition to a history of previous disorders in the patient. Premorbid personality is usually considered well-adjusted. Endogenous depression is viewed as being rooted in some yet undiscovered physiological disorder. As DaFonseca (8) argued, "These states obey inner rhythms." Psychological factors are important in that they influence the expression of this constitutional condition, yielding individual clusters of symptoms. Thus, the usually suspicious person becomes rather paranoid during a depressive phase. Onset in severe cases is often relatively rapid; in the milder cases, more gradual. In addition, there is seldom any precipitating stress present. Although the occurrence of an episode may follow stress, it is usually disproportionate to the amount of stress. Kraepelin (6), for example, cited the case of a woman who became depressed after the death of her husband, then after the death of her dog, and finally following the death of her dove.

The most characteristic experience of the patient is an extreme feeling of sadness and despair, although sometimes this is followed by apathy. Patients also report feelings of inadequacy, guilt, self-reproach, difficulty in making decisions, boredom, dissatisfaction, loss of initiative—thus, a situation where hopelessness is overwhelmingly present. The patient may report crying "for no reason"; later, however, he may be unable to cry. These feelings may be exaggerated to the point of delusions, as of guilt, but hallucinations are rarely seen. Both motor retardation and a phenomenological experience of retardation, e.g., "I can't seem to think as fast as I used to be able to do," are usually present, sometimes to the point of stupor. In some cases, however, patients become extremely agitated. The experience of depression itself seems to the individual to be qualitatively different from exaggeration of normal depression. In addition, there is little mood change in response to environmental change, e.g., "Happy things don't make me happy." The condition seems to be worse in the morning with insomnia usually occurring at this time rather than at bedtime. One account told of the patient who "wakes direct from sleep into his characteristic somber mood or is normal for a few minutes, before, as he says, the depression

'comes down like a cloud' " (20). In addition, general attitude toward the illness seems to be rather objective.

One of the greatest dangers, of course, is that of suicidal attempts. Sometimes the attempt is made before retardation is evident, the patient not being obviously ill, and it is often a determined one (20).

Accompanying physical symptoms include hypochondriasis, sleep disturbances, anorexia, loss of weight, constipation, headaches, aching in the chest, tinnitus, diminishing menstrual flow in women, fatigue—a lowering of all bodily functions. Sometimes syndromes resembling rheumatism, asthma, peptic ulcer and certain dermatoses are observed.

The course of the illness resembles a sine-wave pattern with spontaneous remission of symptoms occurring. These patients, who have an excellent response to electroshock therapy, improve sooner with physical treatments, such as drugs, than without any.

Reactive Depression

In most references where these two categories are discussed, little is noted about symptoms in reactive depression, probably since such a concept is generally accepted in the psychiatric and psychological communities. Such a patient usually has little family history of mental illness, although members of the family may be "nervous." Premorbid personality usually includes a history of instability often involving hostile-aggressive or passive-withdrawal patterns and emotional lability, fearfulness, phobias and a general tendency to overreact to stimuli. Also, there is usually a rather recent history of psychic trauma, more "ego-wounding" than environmental in nature. Onset usually occurs following some precipitating stress—the "straw that breaks the camel's back."

Symptoms displayed are essentially an exaggeration of the individual's previous personality, e.g., fearfulness and withdrawal. The patient usually feels worse in the evening than in the morning, and insomnia usually occurs when going to bed rather than in the morning. In addition, the reactive depressive notes changes in mood in response to changes in the environment. There is seldom any retardation, and suicidal attempts are unusual. Somatization is severe, and the patient usually has a history of frequent trips to the doctor, hospital

visits and operations. General attitude toward the illness is usually subjective in nature.

Spontaneous remission of symptoms is seldom observed in reactive depression. Electroshock therapy is not particularly beneficial and may sometimes aggravate the condition. Psychotherapy seems to be very helpful, although an "improved condition" in a hospital situation usually connotes a return to the previous, unstable personality.

Studies Related to Clinical Features

Evidence based on clinical observations seems to indicate the existence of such a general dichotomy in affective disorders. On the basis of extensive clinical investigations, Kline (17, 21) concluded that evidence does indicate such a classification on the basis of symptoms listed previously. Similarly, Kiloh and Garside (22) used a clinical rating scale in a double-blind study to assess 143 patients diagnosed as endogenous, reactive, and doubtful endogenous and reactive. Factor analysis indicated the total data could have been obtained only as a result of two separate conditions. Using a clinical rating scale, scored either one or zero, Roberts (23) found a pronounced bimodal distribution of scores, indicating the existence of two separate groups with a small degree of overlap.

Another rating scale, the Depressive Category-Type Scale (DCTS) was constructed to ascertain if depression represents two broad disorders (19). This scale is composed of the 15 items most frequently reported in the literature as differentiating between the two groups. Scoring is performed during an interview, which may last from 15 minutes to a half hour. Patients receive scores from 0-2 on the individual items according to predefined criteria. A very definite bimodal distribution of scores in 51 cases was obtained, indicating that two disorders were being measured. The two peaks were at 20 and 30, with possible scores ranging from 15 to 45. Those who obtained a high score, i.e., above 25, were classified as endogenous; those who obtained a low score, i.e., 25 or below, as reactive. Interrater reliability on the first 20 cases, scored by two of the authors, was found to be .87, significant at the .001 level. The items which predicted the total scores best were "Quality Different" and "Course Independent" ($P < .001$); other good predictors were "Depressed Mood," "Retardation,"

"Late Insomnia," "Weight Loss," "Precipitating Factor," and "Affective Family History" ($P < .05$).

In contrast to these findings, Lewis (24), following an extensive clinical investigation, concluded that such a dichotomous classification does not exist, that behavior in these disorders falls along a continuum in frequency. However, his study did not include any objective scales, nor was statistical analysis or description carried out. Similarly, Curran (25), using a symptom rating scale for primary depressives, stated that a "perusal" of his data did not support such a distinction. It is particularly interesting that he asserted that any statistical treatment would be "mathematical nonsense." Plotting his data does not show either alternative conclusively (19); however, patients were studied who manifested anxiety or depression in addition to difficult cases referred to the author. Patterns of scores on the Hamilton Scale have also been used as a basis for assessing the contention that depression is of two types (26). Classifying patients as endogenous or reactive by the presence or absence of a precipitating factor, Hamilton and White found that endogenous depressives had total scores in addition to scores on the first factor, usually associated with retarded depression, significantly higher than did the reactives. Those patients who were classified as "doubtful" had intermediate scores. The distribution of scores was not significantly different from that of the normal curve, but the first factor did have two "humps." The use of precipitating factor alone as a criterion must be questioned, however. In a study of 525 cases of primary depression divided into three groups—endogenous, reactive and involutional—Garmany (27) also concluded that any differences were only between mild and severe. It is interesting, however, that he discovered after the completion of the study that he had selected electroshock therapy as a treatment a majority of times for "endogenous" patients and only a few times for "reactives" (6). If electroshock therapy is helpful in the more extreme cases, i.e., endogenous, then it should also be beneficial in the milder forms, i.e., reactive.

Studies of Physiological Correlates

Perhaps the most convincing evidence for the existence of these two general types is found in the area of physiological correlates. Busfield, Wechsler and Barnum (28), for example,

employed rate of salivary output as a differentiating factor. Using the presence or absence of a precipitating factor, in addition to such factors as "biological predisposition," as a criterion, they selected 52 exogenous, or reactive, depressives and 33 endogenous depressives. Their results showed that the exogenous patients had a significantly higher rate of salivary output than did the endogenous patients. The rate of salivation for exogenous depressives was almost identical to that for patients without depression in a previous study. Perhaps it was that group which accounted for Gottlieb and Paulson's (11) significant results.

A neurophysiological test called "sedation threshold" has been used several times to differentiate between the two groups. The threshold is usually defined as the amount of sodium amytal required to yield certain EEG changes. In several studies (29, 30) the measure of the threshold was defined as that amount necessary to produce the inflection point on the S-shaped curve in EEG readings, usually corresponding to the first point of slurring of speech. It was found that the mean threshold for psychotic (endogenous) depressives was significantly lower than that for neurotics (reactives). It is particularly interesting that this test is now standard diagnostic procedure at Allan Memorial Institute.

In contrast, two studies, using different and less objective methods, were unable to confirm these findings. These thresholds were measured by the first point of speech slurring (31) and continued failure to double numbers (32).

Employing a similar threshold, amount of sodium thiopental yielding a minimum GSR amplitude, Perez-Reyes, Shands and Johnson (33) found a significant difference between groups of endogenous and reactive patients. However, there was no significant difference between normals and reactives.

Differentiation between the groups has also been noted with the use of intravenous injections of methyl amphetamine to groups of endogenous and reactive patients. Observing behavior for several hours following the injections, Roberts (31) felt that, although not objectively measured, there was an undeniable difference between the two groups. One group displayed behavior changing in the direction of normality with an increased improvement of symptoms; on the other hand, the symptoms of the other group became more pronounced with increased agitation, depression and self-reproach. Those whose condition changed in the direction of pathology includ-

ed only one neurotic and 16 psychotics; in the direction of normality, 25 neurotics and 3 psychotics. Although these observations were superficial, Roberts considered them "sufficiently striking to warrant mention."

Another drug, imipramine, was administered in a double-blind study to measure its effects on reactive and endogenous depressives (34). Improvement following a course of the drug was noted in the endogenous group in 74 per cent of the cases; in the reactive group, in 59 per cent of the patients with many still manifesting some neurotic symptoms such as tension.

There have also been reports of differential effects of leucotomies in the two categories. In a group of 105 patients, it was concluded that the reactives had a higher rate of improvement following leucotomy than did the endogenous (35). The author argued that if the two groups were actually the same diagnostically, then the group having the least evidence of a precipitating factor, i.e., endogenous, should actually improve more. It should be noted, however, that if the two groups represent two extremes along a continuum, then the group with less severe symptomatology, i.e., reactive, might improve with the group that is more ill, i.e., endogenous, showing less improvement.

The most impressive and consistent results have been obtained in studies involving the differential effects of electroshock therapy. Using a clinical rating scale to differentiate between the two groups, Roberts (23) tested 20 endogenous and 27 reactive patients before and after a course of treatment. It was found that the endogenous patients had a significantly higher rating of improvement than did the reactives. Similarily, Rose (36) classified his subjects as reactive and endogenous and then assessed severity of depression by means of the Hamilton Rating Scale. One month after a course of electroshock therapy, each patient having had the maximum number of treatments considered beneficial, it was found that the endogenous depressives were significantly more improved than the reactives. Three months later these findings still held true. Another study noted these same differences after a period of six months (6). It is particularly interesting that in one study (29) the sedation thresholds for endogenous patients who were judged as having improved increased to the level of the reactive and normal groups. These general findings have been confirmed in at least three other studies (29, 30, 37).

CONCLUSION

It is concluded, therefore, that evidence does suggest the division of depression into at least two broad groups. The question then arises as to whether this dichotomy is qualitative or quantitative. That the inhibition and sleep thresholds and salivation output of reactives are similar to those of normals with endogenous patients having significantly different rates points to the differences as being qualitative in nature in addition to quantitative. Similarly, differential recovery following electroshock therapy very strongly implies a qualitative difference. If Darvon relieves people of rather strong pain, then it certainly should alleviate the pain in a mild headache. Thus, if the distinction between endogenous and reactive depression represents ends along a continuum, then electroshock therapy, which is excellent for endogenous depressives, should also relieve reactives of their symptoms. On the contrary, the symptoms of reactives are not often alleviated, and occasionally their condition is even aggravated. In addition, two studies, one using the Hamilton Rating Scale for measuring intensity of depression (36) and the other whose subjects were rated as to severity by two or more psychiatrists (28) found that the intensity of depression was about the same in both groups. Another study using the Hamilton Rating Scale, however, led to the conclusion that endogenous depression is more severe than reactive (26). In addition, differential symptomatology, e.g., more retardation and suicidal attempts in endogenous than in reactive cases, suggests that cases of endogenous depression are more severe in general than are those of reactive depression.

It should be added that this classification is not intended to rule out other divisions, for further research may show that there are several groups within each category. Recently a third type of depression, within the reactive group, has been isolated according to patterns on the Inpatient Multidimensional Psychiatric Scale (38). This type is characterized by low scores on "Depression" and high on "Excitement." Hypochondriasis and anxiety are also noted. In addition, types of depressives isolated by Grinker et al. (2) and by Friedman et al. (3) can be incorporated into this classificatory system. Likewise, it would be extremely difficult to classify every individual with primary depression as belonging to one of the two

groups. As Roth (6) very appropriately commented, "Needless to say it is not possible unequivocally to allocate every case to one or another class of depressions; such perfect classificatory systems exist only in heaven."

Further research in this general area is being continued in the Research Division of the Department of Mental Health. With the Depressive Category-Type Scale as a criterion for classifying primary depressives as endogenous or reactive, a number of measures are being obtained. Clinical assessments include the following: the MMPI; the Inpatient Multidimensional Psychiatric Scale; Zung's Self-Rating Depression Scale (39); the Self-Rating Stress Reaction Scale, which is being developed by Dr. I. C. Wilson to measure the sensitivity of the patient to everyday stress; and a questionnaire to measure the facility of recall of emotionally-charged experiences. In addition, the following physiological correlates are being explored: GSR patterns (33); the ankle reflex; and several anthropometric measurements, including transverse chest measurements, height and weight.

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Recommendations for Aftercare Services in a Mental Health Center Setting

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Introduction:

There has been tremendous progress during recent decades in the treatment of emotional illness, with some of the greatest advances having been attained in the treatment of individuals with psychotic disorders. No longer are psychotic patients considered to be wicked people who are infested with evil spirits and thus to be severely punished, nor are they simply provided with the necessities of life in a purely custodial institution. In our day and time, the emphasis has shifted to active treatment for these patients, who are viewed as having developed an emotional illness in reaction to the stresses and strains of life, often in overwhelming proportion compared to the stresses experienced by average citizens.

Yet despite all the advances, a strong element of rejection remains in our public attitude toward those persons who have suffered an emotional illness which has been severe enough to require treatment in a state mental hospital. Although there has been much enlightenment in this regard, a certain stigma is still felt by these individuals when they return to their home communities. The ex-hospital patient feels keenly any evidence of rejection on the part of his family, friends, social groups, fellow church members, or prospective employers.

However, the rejection of these patients is not limited to those who are "non-enlightened" as to the newer concepts of emotional illness. All too often, rejection also comes from professional personnel, as doctors, nurses, and, worst of all, from mental health workers themselves, including psychiatrists, social workers, psychologists, and others. This statement may come as a surprise to some, and yet it is no more shocking than true. Ex-patients of mental hospitals, particularly those who have become medically indigent, often as a result of their disabling illness, are too often seen by professionals as being difficult, cantankerous patients, who have a poor prognosis

for recovery. The process of "buck-passing" is a frequent result, with the patient often being unable to receive any consistent follow-up care unless he returns to the outpatient clinic of the mental hospital, usually many miles distant from his home.

There are certainly many private physicians and community mental health centers which provide excellent follow-up care for these ex-hospital patients, but it is this writer's opinion that aftercare patients feel, more often than not, that they are being treated like "red-headed step-children," even in the mental health centers.

This is not to say that there are not valid reasons for the reluctance of many mental health centers to become more involved in the treatment of aftercare patients. Most of these centers are grossly understaffed, and it is a natural consequence for them to avoid undertaking an extensive aftercare program, for fear of taking away too much time from preventive mental health endeavors and from the treatment of children and adults having mild or acute emotional disorders which respond well to intensive short-term treatment. There is the fear that a comprehensive aftercare program will consume ever-increasing blocks of valuable time, since aftercare patients are viewed as having long-term, almost interminable illnesses, with small likelihood of discharge from clinic care. Also the clinic psychiatrist or medical personnel find it difficult to delegate care of these patients to other professional personnel because the concommitant use of psychotropic drugs requires rather close direct medical supervision of these patients.

Although the reasons used by mental health centers for shying away from aftercare treatment are quite valid, nevertheless, it is this writer's opinion, following two years' experience as director of a full-time county aftercare clinic, that the responsibility for planning a comprehensive aftercare program should fall on the community mental health center. This is not to say that all aftercare treatment should be done in the center, but rather that the planning and coordination of aftercare service should originate from this source.

There are several reasons for this opinion. The state hospital outpatient department should not assume the primary responsibility for aftercare because of a deficiency of knowledge about local mental health resources, lack of availability

for handling emotional crises due to the great distances involved, and an even greater problem with understaffing than that found in the local mental health centers. Neither should the private physician assume the responsibility for planning aftercare services, because his type of practice necessarily limits his knowledge of the various local mental health resources available. Community aftercare clinics, as autonomous treatment complexes, are not the answer, either, except possibly in highly populated metropolitan areas, since smaller communities could not possibly afford both a mental health center and a separate aftercare clinic, nor would professional personnel be available to staff both. This leaves the community mental health center as the logical agency to coordinate aftercare services, since this center is in a position to be most aware of all available local mental health resources, also is available for helping with emotional crisis situations when they arise.

The major problem, then, is to find some means of planning for a definite, effective aftercare program, yet in such a way as to avoid tying up large blocks of professional time. This calls for much flexibility, but it is not an impossible task. It has been this writer's experience that effective aftercare services can be provided with small amounts of clinic time, also that the results obtained are quite gratifying in proportion to the amount of time invested.

The fifty-minute hour, which has become almost a sacred entity with some mental health workers, is certainly not always necessary or even appropriate for many aftercare patients. Neither are extensive diagnostic studies required for aftercare patients, since this has already been done at the mental hospital and is readily obtainable. Many of these patients require only a minimal amount of supportive care, some getting along very nicely on as little time as ten or fifteen minutes every three or four months. *The amount of time spent in an appointment and the interval between appointments are not felt to be of as great importance as providing the patient with assurance that help is available between appointments, if a crisis should arise.* It is this writer's opinion that this latter factor is the most important ingredient in an effective aftercare program, that often more can be accomplished with the patient in a five or ten minute appointment at the time of crisis than in an hour or more at a later time.

Some Practical Measures for Providing Effective Aftercare Services with a Minimum of Time from Mental Health Center Staff:

1. *Referral of patient to family physician, with consultation readily available from mental health center psychiatrist.* In many cases, the family doctor is in the best position to provide the short-interview supportive care described above. He often has a prior good relationship with the patient which would take months for a new person to develop. He should be provided, either by the mental hospital or mental health center physician, with definite recommendations for drug dosages and approximate length of time the patient should continue medication. He also should be given a recommendation that the patient be seen at regular intervals for at least several appointments, even though the interval may be as infrequent as every three or four months in some well-stabilized cases. He also should be actively encouraged to call on the clinic psychiatrist for telephone or personal consultation when problems arise which he feels are beyond his professional competence to handle. The clinic psychiatrist should have the confidential hospital report in his file, so as to be able to advise the family physician as to the appropriate measure to be used with the patient, whether this be to help the family physician in handling the problem himself, referring the patient to a private psychiatrist or mental health center, or adjunctive measures such as referral to Vocational Rehabilitation, a social rehabilitation center, or other local mental health resources. The role of the mental health center psychiatrist should be kept, as much as possible, on a consultative and educational basis, helping the family physician learn to handle as many problems as he can on his own.
2. *Hire part-time general practitioner for routine supportive care and follow-up of medication for indigent patients.* Many aftercare patients, who are relatively well stabilized and who are not motivated, nor good candidates, for more intensive psychiatric treatment, can be managed quite well by a non-psychiatric physician, who would have the clinic psychiatrist available for consultation when needed.
3. *Utilization of group methods for supportive care with se-*

lected patients. We are not referring, at this time, to the usual, more intensive methods of group therapy, which will be discussed later. What we are referring to is a practical, yet effective method for providing some of the supportive care mentioned earlier, and which can be used by the part-time general practitioner mentioned above. Rather than having him rush to see one patient after another, each for ten or fifteen minutes at a time, we have found that selected patients benefit more from a group meeting, in which the doctor chats leisurely with six or eight patients for an hour, discussing mutual problems in adjustment and checking drug dosages. Not only do the patients receive supportive encouragement from the doctor, but they help to encourage each other, in addition to the socializing benefits obtained by these individuals, who have often been quite withdrawn, with much feeling of isolation and loneliness. These are people who can receive much support from such group meetings even at intervals of four to eight weeks, with various members frequently developing spontaneous friendships and meeting socially between regular group sessions.

4. *Referral to public health nurses for follow-up visits to selected indigent patients, with the nurses to be seen in group consultation by clinic psychiatrist.* This is a procedure which we have found to be quite satisfactory for well stabilized patients, with the public health nurses providing the primary supportive care, also observing any adverse effects from psychotrophic medication. Our method has been to have monthly consultations with groups of six to ten nurses at a time for discussion of problems which arise in working with aftercare patients. This has also proved to be an excellent educational and preventive mental health measure, with the focus of discussion often being on the effect of the parent's emotional illness on the children in the home. Since the public health nurse makes a practice of becoming involved with the entire family, in the home setting, she has an excellent vantage point from which to observe early emotional disturbances and to recommend corrective measures for children, who have often been greatly traumatized by the emotional illness and hospitalization of the parent. For this reason, most of our public health nurse referrals have been patients who have

children in the home. Since these are selected individuals who are generally well stabilized on their medications, drug follow-ups by the physician are only needed at very infrequent intervals unless the nurse reports the patient to be getting worse or to be showing side effects from the medication.

5. *Orthodox individual and group psychotherapy to be used when indicated and when permitted by professional time available.* The above measures have not been presented to promote the use of inadequate therapy or overly sparse use to professional time for aftercare patients. Ideally, many of these patients should be provided with much more professional counseling than these methods would provide. However, we are aware of the realistic limitations on the amount of professional time available in the average mental health center, as well as the many different community needs which make demands on this professional time. What we are advocating is that local mental health centers are the logical agencies to accept the challenge of planning for effective treatment to be provided for aftercare patients, rather than joining in the use of "pass-the-buck" maneuvers, which all too often result in no treatment being given at all. The measures outlined can be helpful in preserving professional time so that more intensive treatment can be provided where it is most indicated, and where the benefits obtained will warrant the amount of time expended.

Summary:

Despite great strides in the treatment of psychotic disorders, many ex-patients of mental hospitals experience difficulty in obtaining any consistent follow-up care upon their return to their local communities, even being rejected in many instances for treatment by community mental health centers. This writer is of the opinion that the local mental health center should be the agency responsible for planning and coordinating aftercare services. Realistic reasons for the reluctance of these centers to undertake aftercare treatment are recognized, but some practical measures are suggested as means of coping with these problems. Many patients may be followed primarily by the family doctor, a public health nurse, or a part-time general practitioner hired by the mental health center, with the clinic

psychiatrist available for consultation or emergencies. Group methods in treatment or consultation may be varied so as to provide a further efficiency in the use of professional time. By utilizing these methods, it becomes possible to save enough professional time to provide orthodox individual or group psychotherapy for those cases in which the more orthodox methods are most indicated.

Basic Trends in Community Psychiatry [1]

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Since I am new to North Carolina, I cannot really speak of the trends in community psychiatry in this state, but I have had the privilege over the last few years of working on the national scene and visiting a majority of the state mental health programs over this nation. I have also been particularly privileged to sit on the national committee that has been reviewing the new mental health planning that is in progress in all of the 52 states and territories of this nation. This has provided the opportunity to see how the various states are going about the task of reorganizing and rethinking their operations in the field of community mental health. One of the reasons I was very highly attracted to come to the state of North Carolina after retirement, was the fact that a very solid, sound program has been growing here under the leadership of Dr. Hargrove. In addition, many of us at NIMH have been particularly impressed by the quality of the planning that is going on in this state. If you could know of the wide variety of planning that is going on in this nation, you would come to appreciate that the blending professional viewpoints that is taking place in this state is a really precious thing to behold.

Let me sketch a selected few of the national trends that have impressed me. I think in the last five to ten years ideas that were once theoretical, or experimented with by pilot programs, have now become general trends. I have particularly selected those trends to which the various states are putting more allotments of money, more allotments of personnel, and more allotments of energies. So come and let's climb to the top of the mountain and view the whole battleground of mental health from A to Z—from alcoholism down to Zen. Let's ask ourselves, "How is the struggle going? What are the changes that are taking place? What's new? Is it really good? And what are some of the problems?"

[1] Presented at the John Umstead Lectures, Raleigh, 1964

Let me begin with something which I believe to be the most basic trend. This trend I would call a rapid shift in the basic assumptions behind mental health programing. Now, those are pretty big words, but let me translate them to something more meaningful. An old basic assumption about mental health that was being carried out during first days of the early development of the National Mental Health Act, from 1947 into the early 1950's, was that mental health was a psychiatric problem. I think you will note that gradually over the last five or ten years, mental health is being defined more frequently as a psycho-social, educational, human welfare problem. Some of these words have connotations that medical leaders do not like too well, but these are the words that are being increasingly used to define the nature of the problem. Another old basic assumption was that the major profession in mental health was psychiatry, or psychotherapy. Gradually this has been giving way more and more to the frank recognition that the solutions of the problems we are seeking to solve may require really broad interdisciplinary involvement. We have been saying this for years, but we have really not been doing it as much as we have been in the last few years. The third old basic assumption that psychotherapy is going to be the major intervention process is now giving way to a new basic assumption that multiple processes of intervention are going to be required. Legal, social, educational, medical, as well as psychological interventions, are going to be required and we are going to have to mobilize and utilize all of these social processes if we are going to lick the problem of mental illness and do something about the task of prevention and mental health. A fourth old basic assumption that mental health is a one agency job is also disappearing. When the National Health Act was first passed in 1947, the various governors of each state were required to designate one agency as the state mental health authority of that state. In the various states, departments of public health or welfare or mental health were designated and it was very interesting to watch how the money allocated by Federal funds was spent. It was usually taken by that one agency and spent by that one agency as if they were the sole group in the field of community mental health. This is now disappearing. We are now getting greater recognition that mental health considerations are an integral part of the operation of education,

higher education, welfare, public health, corrections, and other major frameworks of state and local services. Upon analysis, you come to the realization that one cannot take the mental health component out of their mission. It is in there and each such agency has an important part of the entire mental health game. So whenever you ask what basic assumptions are we trying to follow today (I am not saying we have done it yet), it becomes evident that mental health is now considered to be an interdisciplinary and interagency field of endeavor which is going to require a wide range of processes as interventions.

Five years ago this was fine theory, but today you will find major commitments are being made in terms of money, in terms of personnel allotments, in terms of energies based on these new premises. For instance, notice the pattern of nationwide replanning of mental health that is being done by each state. Fifteen years ago it was just one agency doing the planning and the Public Health Service used to receive just one plan from one agency. Now the plans that are coming in are interagency plans. They tell what education is going to do about school mental health, what welfare is going to do about the emotional problems in welfare, what the prisons are going to do about the psychiatric problems they face. This is a dramatic change that is sweeping, not just in your state, across all of the states of this country. For instance, the current mental health centers legislation that has just been passed by our Congress not only calls for programs for the acute mental health problems that we have, but also calls for an analysis of the total range of mental health related human behavior problems. Thus, as you submit plans in order to get funds for local community centers or a state plan to build centers, you will be required to analyze not just the acute needs for the psychiatrically ill but also the needs for the moderate level cases and the mild level of cases, so that a center set down in a community will serve the entire range of severity, not just the acute psychotic or neurotic reactions.

All this adds up to another basic trend. Implementing these new basic interdisciplinary, interagency, and multi-process intervention assumptions will create what I would call another basic trend; the trend towards building *systems of care.* The day of the isolated program, the isolated institution is passing, and we are now talking about the interlock of a whole system

of care that begins in the home, involves one or more community agencies, if necessary uses a specialized institution. Patients will return out of those institutions back into some kinds of community care and back into home care and support until care is no longer needed. So under the trend toward building systems of care for the retarded, for the mentally ill, or for children, we are talking about such things as comprehensiveness of population coverage, serving all kinds of disorders at all levels of severity. We are talking about integrating cooperative circles of services in our communities so that the welfare components are handled at the same time that the psychiatric components and the medical components of the given case are handled. This is now being called "orchestrating care" to meet the needs of patient and family at each phase of the illness. Other words that we use very much these days are "continuity of care," because we realize that the multiplicity of processes that must be brought to bear to handle an individual case of illness or family breakdown is so broad and so diverse that it is necessary to take a person through a series of resources in order to be able to provide them the benefits that we can mobilize for their help. So systems of care, continuity of care, comprehensiveness, orchestration of care, and cooperating circles of services are becoming the goals of today's planning. Although this is a very fine trend, it brings with it tremendous headaches in terms of administration, in terms of understanding roles, and constructively relating the many resources that need to be brought to bear.

A fourth trend that I would like to bring to your attention is what I would call a general revision of the goals of mental health intervention. We are trending away from sole pursuit of personality reorganization objectives toward adding the goals of re-socialization and re-education. I think this arises out of a realistic appraisal of the limited outcomes of psychotherapeutic efforts. Add to this a realistic appraisal of the costs and the time involved in psychotherapy, a recognition of the lack of therapists, and the recognition of the tremendous volume of people that we really must serve. Concomittant to a good hard look at those four factors, you see emerging on the idea scene the evolution of the field of ego psychology, ego analysis, and their methods. Add to this the new interest in cognitive capacities and coping mechanisms, plus the rise

of pretty well defined techniques of behavior re-education, and experiential emotional re-education. All of these discoveries are beginning to give us new tools to work on the re-socialization and re-education approaches and to add these processes to the more time honored psychotherapeutic processes. I think this trend is illustrated by a very interesting comment made by our neighboring mental health commissioner in the state of Tennessee, Dr. Joseph Baker. Dr. Baker had the courage, about four years ago, to stand up before the psychiatrists in his state and say, " The psychiatric profession is professionally immobilizing the full development of mental health care for all people by the 50 minute model." He followed through by spelling out, in somewhat the terms I have just tried to convey to you, the fact that there are other resources, multiple processes, that must be brought to bear to solve this endemic of mental illness. So, these realistic problems of the limitations of psychotherapy and of the dependence upon psychotherapists, plus the possibilities of new approaches, these realistic problems of providing care to a whole population and these newer perspectives have been revising our goals. There are many of us who struggle against this, still feel that this is not an appropriate revision, and that this is going to end up being superficial. I am sure this will be our area of controversy for many days to come. However, if you will listen to the terminology in the literature or on the lips of speakers today, you hear such words as re-socialization, re-education, behavior control, pharmacological containment, social management, stress reduction, protective services. These are now becoming the goals for intervention and care, especially in those situations where personality reorganization is not possible.

Let me hurriedly mention some more specific trends, some of which are really consequences of the generic trends I have been mentioning. Let's explore the rise of school mental health programs, the rise of public education mental health programs as the primary framework for prevention and personality development. The literature was shouting very loudly in the 1950's about the prevention possibilities through the framework of public health which still exist but which still remain largely unexploited. If you will begin to look at what is happening over the nation as a whole, you will begin to find that states and localities are now putting more money, more personnel into the use of the public education framework as

our primary resource for prevention. I understand that this has not yet hit North Carolina, but in states like Ohio, Indiana, Michigan, Illinois in the center of this nation, and especially on the west coast, you will find that the third largest employer of mental health trained personnel are public school systems. Perhaps we have a debt that we owe to the psychiatric television programs maybe and to the national magazines that have reinforced a widespread interest in the psychological mechanisms and psychiatric care. As a result, parents are now putting pressure on school boards and demanding that their teachers know something about the psychology of children, that there be specialized resources available in schools. A dramatic shift in the employment pattern of mental health personnel is now in progress and we are beginning to see that education is being seen as a primary program framework, especially for prevention. I believe we are going to see more and more development in the field of special education, not only of classes for the mentally retarded, but of classes for the emotionally disturbed. We are going to find the strong development of pupil personnel services by school psychologists, social workers, and guidance workers which will need to be carefully allied with the community mental health staff. You are going to hear much more talk about classroom behavior management and mental health orientation of teachers. I believe we will find, as our understandings of ego functioning increase, the development of curriculum conferences in which educators and behavioral scientists will try to build into curriculum those experiences which strengthen basic ego functions. I think this process is really going to revitalize the whole mental health and curriculum field. You will find many more studies and action programs going on in the field of the social psychology of the school community, faculty morale and especially of the mental health aspects of school policy. I choose this to describe because it is a favorite field of mine, but also to say that major revisions of our allocations of money and personnel are being dramatized in this particular area.

Let me move on to a sixth trend. There is a beginning shift in our focus of treatment as all of you know from the state to the locality, down to the local community. This is visualized on a multiple agency basis with the idea of building a system of care within communities of which the "geographic unit"

at the mental hospital will be a part. There are some advantages to providing care closer to home. It has been demonstrated that treatment is generally shorter, there is less loss of income, less loss of jobs, and less loss of family contact. We have found by examining our mental hospital populations that they are not only suffering from mental illness, but they also suffer from social deterioration. As our concern over the prevention of this social deterioration has risen, we are not only revamping our mental hospital programs but attempting to find community alternatives for care so that we don't end up with both mental illness and social deterioration. This transition of the major focus of treatment from the institution in its rural setting back into the community also has some distinct disadvantages. Community acceptance of this responsibility is not yet present in many places. More than that the community tax base for support of this care in the local community is not ready. As yet, there are not enough community oriented mental health personnel who are used to working in a multiple agency, multiple interdisciplinary setting with the continuity of care and flexibility of flow of patients we contemplate. We have very few mental health personnel who are comfortable with this style of treatment as yet. More than this, the state level and local level basis of agency cooperation in multiple care of patients has not yet been laid down in many states and in many localities. In brief, this is going to be a big job ahead if we follow this particular trend.

Let me mention a seventh trend. This trend is the reorganization of hospital care toward inclusion of what I would call a greater community relatedness, a greater continuity of care with community agencies. Most of you in this room know this story, so I am not going to spend much time on it. I would like to point out that the rise of community related programing in our mental hospitals is a distinct trend all over the nation. There are very few of them that are operating without either some sort of an aftercare program or some sort of admissions program in the community. Other hospitals are beginning to move toward geographic units with more investment of their personnel in certain community activities. This is taking place even as we are having a higher percentage of treatment in our hospitals, having increased admissions, increased discharges, even a small fall in the population of

residents. We also are having, nationwide, an increase in readmissions which indicates higher flexibility, lower duration of stay, more programs in training, and more community commitments on the part of mental health staff. But this is only one-half of the big trend change in the hospital care of the mentally ill. The other is the sudden and very dramatic rise of psychiatric units in the general hospitals. All over this country over the last ten years we have seen the addition of psychiatric services to general hospital programs and they have risen from 60 of them in the nation in 1950 to well over 600 general hospitals that now have such services. Before I close let me name an eighth trend: a trend towards new patterns and sources of financing mental health programs. First, I would like to call your attention to the rise in funds for community mental health activities. In 1948 the amount of funds devoted exclusively to community mental health activities was less than $500,000. At that time the National Mental Health Act came into being and the Federal $2.00 was to match $1.00 of local money. At that time states had to put up state hospital budget paper matching, not actually real money, in order to win their first community Federal money. Now turn that around and look at it in 1962. For every dollar of Federal funds that were put in since the year 1948, the states and the communities have now put up over $19.00. So if you will talk about the concept of Federal use of grant-in-aid for seed money, here is a real illustration of it. Putting in a dollar of Federal funds has led now to a flow at the level of 19 to 1 out of state and local funds. Actually, the local and state community mental health funds constituted 2% of all of the funds in mental health in 1956. Now they constitute 5% of all the funds. Even with the big appropriations for our very expensive mental hospitals and which have even gotten more expensive, there still has been a 268% increase in the amount of funds going into community mental health. Secondly, under this trend let me call your attention to the rise of what we call insurance or third party payments for mental illness. In a recent survey, 63 out of 76 group Blue Cross plans covered mental illness to some extent, not enough to the thinking of many of us. Fifty-nine of 76 non-group Blue Cross plans cover mental illness. The coverage varies but the point is that it is coming. I would like to call your attention to a study that was made in the city of New York

in which NIMH agreed to underwrite an insurance company if they would begin to insure for private psychiatric care up to 15 interviews, even day care service. I would like to report to you that the NIMH never had to spend a dime on it. It turned out actually to be so sound that the insurance company never had to dip into the grant to pay for any possible losses. Thus it has been demonstrated that a limited amount of private psychiatric care can be provided through insurance. Not just hospital care, but private psychiatric care in the office and as well as day care. Beyond this, one of the biggest events in mental health care financing that has happened kind of sneaked in on the scene this last year. It did not even hit the papers. When the United Auto Workers fought for a raise with General Motors and Chrysler and Ford, one of the fringe benefits they asked for was complete psychiatric mental illness care, and they got it. Thus psychiatric care insurance and fringe benefits are now coming in as a part of the basic health benefits in union contracts. As this begins to spread over the country, we will not only be working our fingers to the bone trying to deal with people wanting service, but we will suddenly find that there is a tremendous new resource of financing for the kind of programs that we are building in the community.

May I close by saying this. Certainly the psychological era has arrived. Thanks to our television and our magazines and mental health education, and thanks to the fact that we have provided some good services to people, discussion and recognition of psychological problems as well as psychological lingo are on the lips of the people and before their eyes almost every day. No longer are we the mental health leaders trying to lead the people to something good through the wilderness. Mental health programing has become in reality a social movement, a snowballing human cause. Now we, the leaders, are desperately trying to ride on the top of that ball without falling off. We are trying to keep our feet and still guide it constructively. This is a big job, and the challenge is ours. I would like to close with a story told by our friends from Minnesota state mental health program, who were talking about the big job they were facing ahead. They told the story of an Ojibway Indian from the northern part of Minnesota, who was trained as an anthropologist. He decided he ought to study white man cultures so he moved into suburban Min-

neapolis to study white man behavior culture. After he had made a study for about a year, people asked him what he thought was most needed to develop mental health programs in that suburban area. He rose up and squared his shoulders and said, "Na ka lagoomeh wehatah." Which translated means, "If you are going to progress little turtle, put your neck out."

BOOK REVIEWS

(Ed. note: Robert Phillips, M.D. was the author of the book review of Ego and Milieu *by Cumming and Cumming, published in the last issue of the JOURNAL. The reviewer's name was omitted inadvertently)*

SCHALLER, GEORGE B.: *The Mountain Gorilla.* Univ. of Chicago Press, 1963

Before the appearance of *The Mountain Gorilla* facts concerning the life of gorillas were based on, or colored by, anecdotal reports of African travelers, observations of captive gorillas in zoos, and King Kong movies. Schaller's book, based on a 20 month study of *Gorilla gorilla beringei,* has clarified many former misconceptions and presents the first thorough description of this, the largest of all the primates. Indirect evidence suggests that within recent geological history the gorilla was distributed throughout central and western Africa, but now it is confined to two relatively small areas: the lowland form west and north of the Congo River, and the mountain form north of Lake Tanganyika. Schaller's study was confined to the mountain gorilla; mostly those found in the Virunga Volcanos, a divide between the Congo and Nile river basins.

The total population of mountain gorillas is between 5,000 and 15,000. Of these, Schaller studied approximately 200 individuals in ten groups of from 2 to 30 animals. The average size of these social groups was about 17 animals with females comprising two-thirds of the group. A preponderance of females is common in social groups of primates. In both baboon and macaque groups, for instance, females may outnumber males as much as 3 to 1. This imbalance in sex ratio is apparently due to a higher mortality among juveniles and young adult males. Social groups of gorillas also resemble many other non-human primates in that splitting of organized units is infrequent and temporary. The groups wandered over an area of 10 to 15 square miles and moved as much as three miles in one day. No one portion of the area used by a group is defended as a territory and the area used by one group often overlaps that of another. Usually, when two groups meet they either ignore each other's presence or mingle for a short period. When antagonism between groups does occur, it is confined to threats and bluffs.

The social structure of a band is organized about a dominance hierarchy with a single adult male as its leader. The leader is always a "silverback" or fully mature male at least twelve years old. By his actions, he determines the behavior of the entire group. If, as is occasionally true, a group contains more than one silverback male, there is a linear hierarchy among them. Blackback, or younger adult males, rank beneath them and in turn rank above females and juveniles. In many primates, including the chimpanzee and most monkeys, mutual grooming appears to play an important role in social communication. Not so the gorilla. Mutual grooming was infrequently observed and Schaller concludes that it had utilitarian rather than social significance.

The daily routine of the gorilla is quite predictable. An intense feeding period (gorillas are vegetarians) of two to three hours in the morning is followed by a four to five hour rest period. As the day nears its end gorillas again begin to feed and at dark they retire for the day to a newly constructed nest. Each day a crude nest is constructed from herbs and branches either on the ground or low in trees. No tools are used in this, or any other activity of gorillas. They simply pull and break the vegetation, placing it under and around their bodies.

Among the 22 vocalizations emitted by gorillas only 8 are commonly used. The repertoire consists of "grumbles, grunts, hoots, barks, and screams" (p. 380). Chest beating is another communicative act and, when combined with hooting, functions to intimidate potential enemies, e.g., man. This display, given only in its entirety by adult males, may take as long as 30 minutes and consists of 9 distinct acts. It can occur during many states of excitement and begins with the animal emitting clear hoots, often interrupted by symbolic feeding. As he rises to his hind legs, the gorilla often grabs at vegetation and throws it into the air before beating his chest with the palms of his hands. At or immediately after the climax of chest beating the male runs sideways, slapping and tearing at vegetation. A single loud thump on the ground with the hand is the last gesture in the sequence.

The various forms of erotic behavior so often displayed by apes held in zoos is not observed in the wild. In fact, observations of the sexual activities of wild gorillas are surprisingly few: Schaller observed only two copulations in over 450 hours of observation. Apparently copulation can occur without re-

gard to season because the birth of infants, based on their estimated ages, occurs with equal frequency throughout the year. In this respect the gorilla differs from some populations of chimpanzees and from many of the lower primates.

Schaller has written a fascinating story about a dull animal. He reports carefully collected zoological data in a well organized, readable fashion, but leaves theoretical interpretations to the reader. We are indebted to his patience in collecting the data. On the average, dominance interaction was seen only once every four hours, play once in nine hours, and copulation only once in 233 hours of observation. Furthermore, gorillas are apparently unaffected by any predator other than man and live in an area where food is but an arm's reach away. Could such placid behavior be indicative of a species at the end of its evolutionary development? The primary factor resulting in the extinction of a species is a change in the environment to which an animal cannot adapt. Genetic diversity within a population usually enables segments of a population to adapt to a change in environment but, when a species has become highly specialized, it lacks the flexibility necessary to survive.

The gorilla faces an environment being altered by man. Agricultural practices, especially grazing, are rapidly changing the gorilla's environment; too rapidly for it to adapt. Perhaps an examination of another species facing the same types of changes will be enlightening. The habitat of the baboon in many parts of Africa is also being rapidly altered by encroaching agriculture but the baboon is apparently successful in meeting the challenge. In fact, it has become an agricultural pest in many areas. Both the baboon and gorilla are primates but the baboon is approximately one-third the size of the gorilla, is omnivorous, and is far more aggressive. Thus, it seems that the gorilla has become over-specialized for large size, vegetarian diet and, perhaps, for placid behavior. At present the gorilla is not in immediate danger of extinction but with the rapidly expanding human population in Africa it will not be many years before reserves will have to be set aside to save the largest of all the primates.

John G. Vandenbergh

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NEWS BRIEFS

NORTH CAROLINA MENTAL HEALTH ASSOCIATION, INC.

More Participation Assured for Operation Santa Claus Project:

All of the organized local chapters and many counties without local mental health associations have pledged their support and cooperation with the "Operation Santa Claus Project" for 1965.

A project initiated four years ago by the State Mental Health Association has now grown into a state-wide project—to obtain Christmas gifts for all hospitalized men, women, and children in our state institutions. A goal of 20,000 gifts is expected to be met this year.

The "forgotten" patient fund is growing in each hospital—whereby residents without families or close community ties are remembered by interested and concerned citizens across the state.

Local chairmen are working in practically every county requesting gifts and cash donations from civic, church and community clubs in addition to industry and individual gifts.

The theme, "Share Your Christmas Spirit with the Mentally Ill" has caught the public's attention in a few short years to become a year-round slogan of local associations in their efforts to remember patients and let them know "someone" cares. This special project has caught fire throughout the state and has helped spread the Christmas spirit to those giving as well as those receiving—a project well worth the time and effort on the part of local citizens.

Mrs. Nancy Rodman of Washington, N. C. is 1965 state chairman of "Operation Santa Claus" and deserves special recognition for her work this year.

Volunteer Service Committees Increasing:

Mrs. Roy McKeithan, state volunteer service chairman, reports increased committee activity in 1965. With the changes made in the hospital regions, the need for additional volunteer service committees has been recognized and accepted by local associations in all regions of the state. Volunteer activities

are year-round programs with many new faces being seen working in the hospitals and visiting local residents.

Each of the four hospitals now report having divisions of volunteer services with staff assignments made to direct these activities. Car pools of volunteers are visiting the hospitals weekly bringing new life and new interest to patients. With the doors of the hospitals opening to the public—this is creating a better understanding of patient needs while at the hospital and also when he returns to his home community. The volunteer has become a welcomed part of the hospital staff—and his work is being recognized as the needed "missing" link between home and hospital.

Board of Directors Meet in Raleigh:

The quarterly meeting of the Board of Directors for the State Mental Health Association was held in Raleigh on December 2nd. The group re-stated their concern for the continuation of the Wright School for Emotionally Disturbed Children in Durham. Local leaders were urged to express their concern to their General Assembly members and to the Governor in recognition of the need for state appropriations in 1967 to continue the school in North Carolina.

A recommendation was approved to add "Prevention" to the already established goals for "Improved Treatment and Patient Services" to the state-wide program of the Mental Health Association.

Mrs. J. B. Spilman Honored:

The "Merit Citation" was presented Mrs. J. B. Spilman, executive director of the North Carolina Mental Health Association. It was presented by the North Carolina Public Health Association at its annual meeting held in Durham, N. C. in September.

The citation praises Mrs. Spilman's leadership in her state's action in behalf of the mentally ill since she accepted the task of coordinating citizen interest in this field in 1957. Special tribute was paid to her initiation of a massive program of public education and to her success in involving state government and organized medicine in efforts to provide better mental health services.

Mrs. Spilman continues to improve the effectiveness of the

Association. The fifty-two organized county chapters are extending their services to patients and volunteer services to the hospitals and community clinics under the guidance and direction of Mrs. Spilman.

North Carolina Well Represented at the National Association for Mental Health Annual Meeting:

Fourteen members of the North Carolina State Mental Health Association attended the New York City Annual Meeting of the National Association for Mental Health in November. The North Carolina delegation was headed by Mrs. Herman Clark, president, of Fayetteville, N. C., and past president, Rev. Orion Hutchinson; along with Mrs. J. B. Spilman, executive director. All sections of the state were represented by the 14 delegates.

Mrs. Winthrop Rockefeller was re-elected President of the National Association at the New York meeting. Some one thousand persons were in attendance at the three day meeting.

Program emphasis was on community treatment services with special workshops held on multiple phases of the National Association's program activities, including: volunteer services; rehabilitation services in the hospitals and in the community; Chapter Board organization and responsibilities; legislation; recruitment and training of personnel; and public education to help bridge the gap between hospitals and community services.

Recognition was given to the successful results of the National Legislative Conference held in Washington, D. C. last March and its effect and influence on the Mental Health Center staffing bill passage this fall. Mrs. Rockefeller pointed with pride to the role of the volunteer citizens' groups across the nation in helping obtain this needed and important national legislation.

Senator Javits of New York and Represenative Fogerty addressed the general session, pointing up the close relationship of the mental health associations and the state and local efforts in promoting the Economic Opportunity Act. Each urged the citizens groups to join forces with local and state government in utilizing its best energies in attacking the problems of poverty as a means of alleviating many of the emotional and mental illness problems within communities.

State Association Continues its Training Programs for Local Leaders:

Under the sponsorship of the State Mental Health Association, a workshop for presidents, executive secretaries, and education committee chairmen of local chapters was held at Southern Pines in October. In late January, a similar workshop for chapter officers will be held in High Point, N. C.

Annual Meeting Scheduled March 3-4, 1966 in Charlotte:

Mrs. Janis Griffin, Chairman of the Annual Meeting Program Committee announces the 1966 Annual Meeting to be held in Charlotte, N. C. on March 3rd and 4th. Mrs. Winthrop Rockefeller will be the featured luncheon speaker on March 4th. The theme of the Annual Meeting is: "The Community as the Battleground in the Fight Against Mental Illness."

The conference will again be a joint meeting of the Mental Health Association and the Medical Society of the State of North Carolina.

The Honorable Bert Combs, Governor of Kentucky, will be the banquet speaker on Thursday night, March 3rd. His subject will be "State-Community Responsibility in the Fight Against Mental Illness."

Wake County Mental Health Association Sponsors Annual New Year's Eve Ball in Raleigh:

New Year's Eve will again salute the mentally ill by a gala Crystal Ball and Buffet Breakfast to be held in Raleigh at the Memorial Auditorium. An evening of top entertainment is promised to all attending. Proceeds from the Ball will be used by the Wake County Mental Health Association for patient services, public education, and patient rehabilitation.

UNC-DUKE PSYCHOANALYTIC TRAINING COMMITTEE:

The University of North Carolina-Duke Psychoanalytic Training Committee has been given Provisional Institute status by the American Psychoanalytic Association at the mid-winter meetings. The Institute is unique because of the fact that it is under the aegis of two Departments of Psychiatry in two university medical schools, the University of North Carolina and

Duke University. The five training analysts of the Institute are Drs. Bernard Bressler, Professor of Psychiatry, Duke University; John Rhoads, Professor of Psychiatry, Duke University; David Young, Clinical Professor of Psychiatry, University of North Carolina; Milton L. Miller, Professor of Psychiatry and Chairman of the Psychoanalytic Training Committee, University of North Carolina; and George Ham, Clinical Professor of Psychiatry, University of North Carolina. In addition, the Institute faculty includes Dr. David R. Hawkins, Professor of Psychiatry, University of North Carolina; Dr. Sanford Cohen, Professor of Psychiatry, Duke University; Dr. Rex Speers, Associate Professor of Psychiatry, University of North Carolina; and Dr. Virginia Clower, Clinical Associate Professor, University of North Carolina. There are twenty-two candidates in training at this Institute.

NORTH CAROLINA NEUROPSYCHIATRIC ASSOCIATION & DISTRICT BRANCH OF THE AMERICAN PSYCHIATRIC ASSOCIATION

Notes From the President

I am grateful to the editor for this opportunity to write about N. C. Neuropsychiatric Association details. At the present time, I am trying to study the constitution and by-laws of the organization so that I can see how these fit and misfit with those of the APA District Branch for North Carolina.

As you know (if you attended the Greenville meeting) the officers of the NCNP used to take over from October to October whereas the APA office bearers become official from the last day of the May APA meeting. This has led to a great deal of confusion. For example, last May at the New York meeting I attended the lunch for presidents-elect of district branches. Now it seems that Philip Nelson should have been there rather than me.

The decision made at the Greenville meeting was that the present group of office bearers should remain in office for an eighteen-month period, through the 1967 APA meeting. Those elected at the October 1966 meeting will then become office bearers in both organizations on the last day of the APA meeting in 1967.

One of the complications within these two organizations is that the treasurer and secretary positions rotate in alternate years with the appointments lasting for two years each. This means that voluminous records have to be passed on from person to person and that people who are needing to work together may be living in widely separated places.

It seems to me that a good solution would be to consider the appointment of an executive secretary. The two organizations are big enough to warrant such an arrangement, I believe. It certainly seems desirable to have an honorary treasurer and an honorary secretary as at present but we might relieve these gentlemen of the onerous and unpaid duties that have befallen them in the past and at present. Incidentally, for the record, Dick Proctor remains the secretary for the next eighteen months and Frank Kane is the treasurer for a two-year period which, in this case, should run for thirty months.

Asheville Meeting

The North Carolina Medical Society Meeting and the APA national meetings are, finally, scheduled for different weeks. Some of us have been agitating for this for quite some time. I am not sure if the 1966 situation has occurred by chance or by design, but in any case let us now show the non-psychiatrists throughout the state that we are physicians and active members of the medical society. Bob Harper and I have had some conferences regarding the psychiatry section meeting to be held at the time of the medical society meeting on Tuesday afternoon, May 3rd. We are planning to have an interesting panel to discuss psychiatric and other aspects of therapeutic abortion and possible suggestions we may wish to offer our state legislators. Please plan to attend.

Annual Meeting

Pease mark your calendar so that you will be free to come to Chapel Hill on October 21 and 22. We will have several nationally prominent speakers in a program which will include scientific papers, a business meeting, social events, and clinical activities. The meeting will continue all day Friday and will offer clinical seminars on Saturday morning. Football fans will have a chance to see a game on that day (UNC vs.

Wake Forest) and we are reserving blocks of accommodation so that those who plan ahead can be guaranteed a room and enough attractions to make a two or three day visit well worthwhile. Harry Golden has agreed to talk at the Friday night dinner and we hope that a recent APA president will also participate. More details will be published later.

John A. Ewing, M.D.

Following is a list of the current officers of the Association:

President: John A. Ewing, M.D.
Chairman, Department of Psychiatry
The Medical School
University of North Carolina
Chapel Hill

President-elect: Charles R. Vernon, M.D.
Deputy Director
N. C. Department of Mental Health
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Vice-president: Paul G. Donner, M.D.
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Secretary: Richard C. Proctor, M.D.
Bowman-Gray School of Medicine
Winston-Salem

Treasurer: Francis J. Kane, M.D.
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Here is a complete roster of the Association's membership for 1964-65:

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This journal is intended to be inclusive rather than exclusive and is not meant to be regarded as simply a house organ of the North Carolina State Department of Mental Health.

It is hoped that the journal will reflect the broad-based philosophy of psychiatry current and will draw on areas reflecting the total spectrum of psychiatric and neurologic thought, program and research.

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(Notice to contributors — see inner back cover)

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DEPARTMENTS

"AKINONISIA"

(The Social Breakdown Syndrome*)

N. E. Stratas, M.D.

Deputy Director, N. C. Department of Mental Health

"AKINONISIA: Unsociability, unsocial, uncompaniable"

This is a socially determined reaction pattern and, therefore, an important target for corrective action both within our mental institutions and in our community mental health programs. It is found in mental disorders as they become chronic, whether they be of functional or organic basis. It is responsible for many of our institutionalized patients and is responsible for many of the social disabilities seen in these illnesses. It is found in many persons never institutionalized, however, we shall deal in this paper primarily with the institutional setting.

One of three patterns may be seen emerging as the deterioration of the affected persons' social relationships occur. These are: (a) withdrawal, (b) striking-out behavior, (c) combinations of both.

Withdrawal is marked by loss of interest in the surrounding world, which may range even to a marked inner fantasy life. Interest is diminished or lost in social functions such as work responsibilities, housekeeping, personal appearance, dress and bodily cleanliness, eventuating in extreme form in a deteriorated, dilapidated, apparently uninterested and unresponsive individual who seems to blend in and become part of the inanimate environment.

Striking-out behavior is exemplified by resentful, quarrelsome and hostile behavior, which may be inflicted upon physical objects, household fixtures, oneself, or others in the environment.

Combinations of both of these may appear in an individual with striking-out followed by immediate withdrawal only to be followed sometime later by further striking-out. The syndrome of anger and hostility is especially responsible for much of the present rejection by general hospitals of mental patients as a whole group.

* See *Mental Disorders: A Guide to Control Methods.* American Public Health Association

Much has been written about depersonalized institutionalization and this certainly is capable of producing this syndrome. However, the syndrome begins in the original living situation of the individual and is entangled amidst the interplay of interpersonal communications plus the emerging identity as seen and defined both by one's self and by persons around him. It has been demonstrated in "open wards" that much of the anti-social and withdrawn behavior of mental patients disappears when they are treated as responsible human beings and presented with unambivalent, consistent, and realistic environments.

Although the rapid demise of the large mental hospital has been ardently and perhaps wishfully predicted, it is apparent that our hospitals will continue to play a significant role in the management of a large segment of mental disorders for the foreseeable future. It behooves us, therefore, to examine critically the social structure of the mental hospital and its role in improving social functioning. In the past, the patient has tended to be insulated and excluded from the family and from participation in community life, as for many years the mental hospital has had as one of its primary functions the protection of the community from unwanted members. We now see that this very function may contribute to the syndrome herein described!

Recently, we have seen marked efforts to develop our hospitals as residential centers of treatment and, indeed, marked changes have occurred to begin the transformation of our hospitals into "therapeutic communities."

To anticipate and avert institutionally induced deterioration in patients entering the hospital is of primary importance. In an over-protective institution, there is danger that the restricted opportunity for reality testing hampers not only the patient but also the hospital staff's understanding of the patient and may lead to either under or over-evaluating the patient's capacity for functioning acceptably outside this setting. A program which offers transitional types of treatment will enable the staff to see the patient in more than one context and thus will minimize this.

It is not enough to consider a "total push" program as being a total institution program. Rather, it must be a total community program of which the hospital is simply one element. Attempts to control social environment and thereby

influence the course of the patient's illness are not by any means new, as they were utilized in hospitals over 100 years ago.

The findings of experiences in England's "open hospitals," in programs of "total push," and findings of social scientists have combined to make it obvious that the hospitals must now, long overdue, see themselves and be seen truly in the role of one element of a total community network.

This demands that the hospital be closely scrutinized to assure that the dynamics of a "therapeutic community" are truly in existence. We might define the therapeutic community as one which provides a setting which balances physical, psychologic, and social stimulation with physical, psychologic, and social support to provide maximum opportunity to the maximum numbers of patients to develop their individual functional capacity by active participation in a healthy living experience. Although we are not certain how specific measures contribute to or detract from this goal, still a number of techniques have been found useful to this end.

Social grouping must be carefully attended to. The difficulty patients have in initiating group relationships is one of the reasons they deteriorate. Our patients, even the sickest, will respond in some degree to social opportunities and will try to conform to standards of a group of which they are a member. Thus, if a nurse or aide forms a group and interacts intimately with it, the group norms which emerge are likely to conform to standards of behavior of the nurse or aide. This demands that the nursing staff members become sensitive to personal, interpersonal, and social dynamics in healthy and pathologic forms and be skilled in presenting alternatives to groups. Much can be said regarding the personnel, their selection, training, and coordination; however, this can make for a separate discourse. In general, we should strive to have nursing staff personnel who have shown healthy adaptive behavior themselves in the past, given didactic and supervised clinical experience to provide behavioral and social insight.

When the groups are made up of both men and women, the patients respond to the presence of the opposite sex by demonstrating increased awareness of personal appearance and restraint in behavior. Spontaneous associations on the ward can be encouraged with groups formed and assigned to a

nurse or aide who have responsibility for instituting a total activity program. Once groups are established, it is important to move beyond regimented procedures, and patients need to be drawn into planning their own activities. As the functioning of the patient group moves to higher level, the activities in which they engage can more clearly mirror those which are characteristic of groups in the extramural setting of the community.

Patient-government can be encouraged and facilitated. Opportunities for meetings of the total patient group should be provided, even if this is not structured as patient-government. These meetings may initially appear unproductive; however, it is important to remember that the purpose of these activities is to promote patient interaction and to develop patient capacities.

Group therapy has been too little used in helping the long-term withdrawn patient. Most hospital patients often have difficulty in adjusting to the close interpersonal relationships of the family situation. Perhaps even situations which include members of the patient's family in the group therapy sessions can be contrived.

Work and play are other vital necessities in the hospital program, not so much in terms of the traditional "work therapy" and "recreational therapy" as much as in the sense of an attempt to organize patterns for living. Thus, work as meaningful work assignments which can be graded as the patient improves and which are interwoven with a programmed day of other events in which the patient is an active participant must be developed. It is probably better in considering activities to utilize the immediate surrounding community wherever possible. It is probably better for many patients to attend church or go to the movies in the community rather than within the hospital. It is important that this type of program where worked out not become a permanent way of life but instead be graduated toward return to community living.

The ideal situation would have these programs interdigitating with active rehabilitation programs so that the patient progressively moves through a series of events which prepare him to make a transition to the extramural setting which is in keeping with his total mental and physical ability, and rehabilitation must provide for both.

Community orientation can be achieved by the hospital by establishing two-way streets. Community staff can be utilized within the hospital, and, similarly, hospital staff can be utilized in community programs. Volunteers can and do come into our hospitals; but also patients can go out of the hospital to participate in community functions. The use of hospital facilities for community functions such as night courses, mental health programs, art classes, can be mirrored by the use of community facilities for patients, as in shopping, attending concerts and plays, and participating in religious activities.

The physical structure of our hospitals is important and often unfortunately arranged! Many things cannot be changed; however, minor alterations, keeping in mind individual patient and group needs, can do a great deal to make the ward and activities area take on some of the atmosphere of home, work, or play. Furnishings can be similar to those customarily used elsewhere. Rugs and drapes, very often made by patients in work settings, can be utilized to soften harsh surroundings or minor physical alterations of ward space can provide areas which are more suitable to small-group association. Even if this cannot be done, much can be accomplished by the manner in which furniture is grouped.

The orientation of the patient in time and space needs to be carefully considered. For example, locked doors, if they are necessary, which have an explicit label, such as "storeroom" can help or a plan of the hospital and its grounds can be displayed on the bulletin board, along with a state map; perhaps a map showing the counties served by the hospital may be put up. A reading room with hometown newspapers will serve to increase dual interest in home and hospital. Certainly, at least, newspapers of the surrounding area should be on the wards. It is unfortunate to state that orientation is commonly neglected where it might be made easier for the patients with a large calendar and, perhaps, with the day, month, and year on the bulletin board. Clocks are certainly essential at home, and there is no need to consider them dispensable in the hospital.

In order to provide the patient with some information about himself and his appearance, we ought to have at least one full-length mirror with other smaller mirrors for grooming. Bathing whenever possible should be available to the patient

at appropriate times, and mass assembly-line operations should be discouraged and minimized.

Patients should have a place to keep their clothes and other belongings and should be encouraged to do small amounts of personal laundry on the ward.

With almost no disruption to present operation, daycare and nightcare programs can be effected and certainly are to be strongly encouraged where patients are from surrounding communities.

There is no reason that some of our wards cannot be utilized as some have been and called "quarter-way houses," where the patient keeps his own medication, assists in buying and preparing his own meals, and has the major responsibility for his own activities.

Sheltered workshops, either in the hospital or in the community, where patients can go during the daytime, are finding their way into our operations and can certainly play a big part in rehabilitation.

New approaches to mental disorders necessitate a continuous process of education in the community and a keen awareness of our intramural programs so that we are, in fact, minimizing the syndrome of akinonisia.

*A State Looks to the Future**

EUGENE A. HARGROVE, M.D.

Commissioner, N. C. Department of Mental Health

The task of introducing these Third Annual John Umstead Lectures on Child Mental Health is a difficult, challenging one. To the extent that my remarks are not specific, they will not be entirely satisfying. Nevertheless, I hope I am able to raise some questions and stimulate discussion and hopefully point to some new directions for the future.

It is important to recognize that no one group has a corner on correct questions or answers regarding mentally handicapped children's problems or how to enhance the mental and emotional development of children. There are large gaps in basic and applied knowledge, but it is apparent that enough is known right now to enable us to make substantial progress if we use what we know.

I see no magic, simple or single solution to the mental health problems of children. There is no one solution. Long-range goals may be shared by the state and most communities; but resources, needs and readiness are so variable locally and regionally that short-range goals must largely be determined at the local level after discussions and these will vary widely. Without strong local mental health initiative and leadership progress will be slow indeed.

In addition, consultation, leadership, development of standards, planning and coordination need to come from the state level and the universities. The State Department of Mental Health and other agencies share responsibilities for public, legislative, and agency education.

Before focusing on some of the needs for the future, I would like to review briefly the state's *present position* in regard to resources and services for mentally handicapped children.

Thirty-one local mental health clinics or centers (two of these child guidance centers), offering services to 51 of our 100 counties, served 21,623 patients in the fiscal year that concluded last July 1; 8,015 (37%) of these patients were under 20 years of age. Total budgetary support for these

* Delivered at the third annual John W. Umstead Distinguished Lecture Series, February, 1966, Raleigh, N. C.

services has increased five times and the patient load 60% since July 1963. Consultation and other services to schools and other agencies and professionals are widely offered on at least a small scale.

Four regional state mental hospitals containing approximately 10,000 beds admitted 13,679 and separated 14,196 patients in the last fiscal year, a 31% increase in admissions since fiscal 1963, and a 90% increase in separations. Nearly 5% of the cases admitted were under 20 years of age.

Four regional centers for the mentally retarded with 4,500 beds, serving the retarded and other types of mentally handicapped, admitted 508 and separated 166 patients, most of them children, in the last fiscal year.

Some of the more *differentiated services* for mentally ill or emotionally disturbed children in North Carolina are:

1) 3 child psychiatry or child guidance clinics located at Duke, Winston-Salem, and the University of North Carolina at Chapel Hill.
2) Child psychiatry training programs, one at Duke University and the other at the University of North Carolina in addition to the 5 general psychiatric training programs, the School of Social Work at U.N.C. in Chapel Hill, and the various psychology, special education and other training programs.
3) A beginning program training teacher-counselors for disturbed children at Duke University.
4) A diagnostic clinic at Murdoch Center plus more limited-function clinics at Caswell and Western Carolina centers.
5) 9 developmental evaluation team clinics under the State Board of Health operate in Cullowhee, Asheville, Charlotte, at the 3 university medical schools and in High Point, Greenville, and Wilmington.
6) A 20-bed children's psychiatric unit at Murdoch Center, Butner.
7) Wright School in Durham is a 24-bed residential facility for the treatment of disturbed children. I am glad to report that the budgetary crisis resulting from failure of the last Legislature to appropriate funds for operation of Wright School during the second year of this biennium has been resolved. Funds from various sources have been committed which will enable the school to

survive until a request can be made to the next State Legislature.

8) A new unit serving 40 children in the 10-16 age group has recently opened at Cherry Hospital in Goldsboro.
9) The Adolescent Unit at Umstead Hospital in Butner offers treatment for 40 disturbed adolescents.
10) Alexander Children's Center (formerly Home) in Charlotte under private non-profit auspices, is moving into a new facility and expanding its capacity from 18 to 36 children.
11) A limited number of crisis beds are available at Western Carolina Center; short-term beds are available at O'Berry Center and on a more limited basis at the other centers for handicapped children.
12) Of course, some children, particularly adolescents, are admitted to adult wards and units in the mental hospitals. We need to know more about the advantages and disadvantages of this practice.
13) Very many of the children admitted to the state residential centers as mentally retarded, particularly in the less retarded groups, have major primary or secondary emotional or behavior disorders. Here the deficiencies in our diagnostic concepts and nomenclature are striking. Perhaps we need a diagnostic scheme that gives more weight to dysfunction of family, school, and community systems. Although it belongs here, time prohibits attempting to describe other programs in the centers for mentally handicapped children. Considerable experimental programming is being tried and offers promise for the future.
14) An expanded network of services for those over 16 is being developed through Vocational Rehabilitation, often with active participation of state and local mental health agencies. These services include several counselors in regional offices; half-way houses in Greensboro, High Point and Charlotte; 16 sheltered workshops located throughout the state; joint programs emphasizing vocational training at our regional hospitals and centers.

"Mental Health Services for Children," the joint report of committees from the N. C. Mental Health Association and the State Medical Society, headed by Dr. Lloyd J. Thompson, represents the first organized effort to assess needs and suggest

steps in this important area. This effort must be considered as a basic resource in planning for future development. Copies are available from the sponsoring state organizations.

All the presently existing resources and programs indicate that our state has not been unaware of the needs of mentally handicapped children. But current efforts are as yet grossly inadequate. Many needs are unmet. They demand our attention.

One of our most pressing needs is to enlist more friends, particularly among political leaders and legislators. We must be able to communicate our needs and our programs at a grass-roots level. We must give more attention to "packaging" our needs and presenting them in an effective and compelling manner. Exactly what are we asking the public to assume? This is a shared task for us all and one in which we should try new and creative approaches.

Let us face the reality that our manpower and budgetary limitations are and will remain real and large. But this fact must not be used to evade looking squarely at the demands that society places on us. We must assist in identifying needs and possible solution alternatives. A defensive posture in which we retreat behind our limitations serves little useful purpose. However, manpower limitations make essential creative exploration of the most efficient uses of professional time; as by utilizing semi-professionals, teachers, and others to provide direct services with supervision or consultation from mental health professionals.

It seems especially important that mental health professionals be willing to *extend* themselves to work with other groups and other agencies in a mutual exploration of difficult problems such as how to bring mental health services to children of poverty, and ways of approaching primary prevention of emotional disorders. We must learn much more about the perspectives and problems of the teacher and classroom if we are to be of maximum use to schools and similarly for other disciplines and settings, as well as the total community. New, exploding programs that need participation and advice from mental health professionals include anti-poverty programs and local school projects now being submitted for support by the Federal Elementary and Secondary Education Act.

While we must be flexible in our professional endeavors, we must, nevertheless, periodically clarify our roles and not

lose our identities or sound clinical programs. We must be wise enough to keep what is best from the past but persist in our efforts to find new methods, new and renewed relationships and new allies in our efforts.

Ultimately, of course, a *wide range* of *services* for children will be needed containing many of the following elements at local or regional levels, some already present in many places in North Carolina.

1) First, a multiplicity of diagnostic and evaluation services will be required of varying orientation and sponsorship but, hopefully, coordinated functions.
2) Consultation, education, and training programs of many types, with particular focus on the public schools, but also extending to family and juvenile courts and correctional programs, are important.
3) Mechanisms need to be built in for continuing evaluation of programs.
4) Out-patient treatment including group and family counseling or therapy is also needed.
5) Other essential components include day care, possibly partial hospitalization for children, and improved and expanded foster care, group care and temporary emergency shelters.
6) We will need to assist in bringing about more and better special education, recreation and camping for the mentally handicapped. It is encouraging that much progress has been made in providing special education classes for the retarded in the community; however, only small beginnings have been made in offering similar programs for the emotionally disturbed child. As a result of action taken in the last Legislature, teachers for many of our hospitalized emotionally disturbed children have been employed and classes are now ongoing.
7) Additional programs of short-term residential schooling, cognizant of the Wright School model, will be necessary.
8) We will have to provide intensive residential treatment for at least short and moderate terms, and probably long-term residential care for the chronically ill child although I wish we could create a more constructive alternative to this last.
9) Progress is being made in extending vocational counseling, training and placement services plus opportunities

for sheltered employment to handicapped children; and this development must continue.

10) Discussions on planning and goals, programs and problems should be a major part of our public education responsibility and should be utilized to help develop public support. Expanded and improved public and agency information services are needed. We might explore local or regional registries or other types of shared record keeping.

I hope that in the future we will be able to stimulate more "partial" or consultation referrals from other health, welfare and educational agencies, with joint case planning and shared case responsibility. The need for improved communication between staffs of mental health programs regarding child patients and their families, as well as other topics, becomes more evident each month.

It seems to me that our progress in meeting the mental health needs of our state's children will depend in part upon our ability to maintain flexible approaches and to sustain continuing discussions between agencies, disciplines, and citizen leadership at local, regional and state levels. We must be willing to modify or terminate experimental projects which continuing evaluation shows are not working for the benefit of the children, families and communities and try other approaches. Rigidity is a major enemy.

I am sure you are looking forward, as I am, to other presentations of needs and possible models for meeting these needs later in the program. The place of specialized programs for children on either out-patient or in-patient bases remains unclear; the basis for grouping children in residential programs needs further clarification; which of the more specialized programs should be developed on a regional, as opposed to a local, basis and the types of programming and responsibility for children that the regional mental hospitals and retardation centers will assume in the future remain to be determined.

I have touched lightly on a number of problems. The program today and tomorrow is designed to present problems and opportunities in more depth and in relation to what other states are doing and planning. We have a good base of services for children that provides a launching site as we look to the future.

HYPNOSIS

Summary of Current Status in Medicine

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Hypnosis may be conceptualized as a state of mind (hypnotic trance) or as a procedure (hypnotic method).

Hypnosis as a State of Mind: Qualities characteristic of hypnosis may be observed commonly in everyday life. Witness, for example, the student immersed in study or the child engrossed in play. They have narrowed their attention to an extent similar to the hypnotized subject. This focus of attention is an essential quality of hypnosis; however, in the case of hypnosis, the attention, or a significant part of it, is typically set on a person, the hypnotist. Another natural life example of a hypnosis-like state of mind is the phenomenon called "falling in love." This, too, has characteristic features in common with hypnosis. In this instance, the individual is unequivocally and often helplessly, even though happily, under the influence of the loved one, a condition similar to that which is sought in the hypnotic state of mind. Are there not many other instances of naturally occurring hypnotic trances available even to the casual observer?

Four features characteristic of hypnosis as the term is used technically and hypnosis as seen, so to speak, in nature may be described:

First, there is an extreme degree of concentration, a narrowed field of attention, in which much of the available sensory input, both from internal and external sources, is selectively excluded and controlled.

Second, there is relative subjugation to an object (e.g., the hypnotist) or to a task (e.g., a study). It can be described then as selective attention and selective inattention, classically with the hypnotist making the selection for the subject.

Third, hypnosis as a state of mind may be described as an altered state of ego functioning: perception, cognitive processes, memory, ego defenses, affect, and behavior are altered in varying ways, setting the stage for the fascinating phenomenon called suggestibility, an apparent heightened capacity for certain types of learning. In many respects hypnosis re-

sembles, or may legitimately be descriptively classified as, a dissociative reaction, "artificially" or "voluntarily" induced.

Fourth, accurate definition of hypnosis should include a description and understanding of the relationship between the hypnotist and the subject. In this respect, it appears to be an example of the psychodynamic mechanism of transference as described in psychoanalytic theory. An internal image of authority and respect, to a large extent developed through parental relationships, is externalized onto the hypnotist. Similarly, counter-transference may be implicated in the state of hypnosis; and, indeed, it may be an essential ingredient of the traditional hypnotic phenomenon!

Hypnosis as a Procedure: Various levels of hypnosis have been described. In the very light trance or hypnoidal state, relaxation, fluttering of the eyelids, closing of the eyes, and complete physical relaxation are described. As the trance deepens, there is catalepsy of the eyes and limbs and finally anesthesia. In the medium to deep trance, there is partial amnesia, the capacity for a definable posthypnotic effect, personality alterations, kinesthetic delusions, complete somnambulism, negative auditory or visual hallucinations, as well as other regressive phenomena. Presumably, suggestibility is related to depth of trance, but this remains unproved.

Hypnosis as a procedure offers a setting for the study of certain specific psychologic and psychophysiologic phenomena. Various psychologic and physical maneuvers are utilized in hypnosis to facilitate the induction of the trance. These maneuvers constitute the hypnosis method and have in common the attempt to change the rate and amplitude of sensory input. Further, there is an alteration in the alerting mechanism of the organism. Presumably any normal person can be hypnotized, but not necessarily by any person. A mentally ill patient may be hypnotized, but often with difficulty. Apparently, hypnotizability and degree of mental illness are inversely related.

Techniques of hypnosis, or methods of induction, fall into the following groups: the direct authoritarian, the indirect or permissive, and the mechanical techniques. Commonly varying admixtures of these are utilized. Methods of direct induction include eye fixation, suggestion of fatigue and relaxation, drowsiness, and the use of idiomotor and idiosensory suggestions. For example, the hypnotist may indicate a wish on the

part of the subject to close his eyes, feel his eyelids getting heavy, or feel a sense of tiredness and drowsiness. A number of other direct techniques including certain signalling maneuvers are recommended by various experts in the field.

In indirect methods, trance induction may be suggested through the use of sensory imagery. A subject may be asked to imagine a familiar relaxing situation or visualize himself performing some perfunctory or monotonous activity. Mechanical techniques draw on the use of certain gimmicks such as the metronome, hearing discs, or electronic instruments. Certain individuals are capable of hypnotizing themselves, and such autohypnosis may often be useful in a therapeutic program.

Hypnosis in Medical Practice

Hypnosis has found a number of uses in medical practice. In non-psychiatric medical applications, there is a current surge of interest in its use. However, in the past, over-enthusiasm on the one hand and exaggerated skepticism on the other have often been polar extremes precluding a rational and systematic approach to the clinical use of hypnosis. As a result, it has come in and out of favor repeatedly over the years.

For the relief of pain and anxiety, hypnosis has proved valuable and a practicable procedure, particularly popular in surgery and obstetrics, but also in general medicine. It can be helpful as an adjunct to drug therapy or helpful in reducing the dosage when anesthetics, analgesics, or sedatives are indicated. In these instances its use may enhance the effectiveness of the drug, or indeed, replace it.

In psychiatry, hypnosis has had a long and stormy history. Although time honored as a psychiatric procedure, Freud's abandonment of hypnosis and development of the psychoanalytic technique in the 1890's seem to have influenced the curbing of hypnosis in psychotherapeutics until most recently. It has now become popular again, but more and more is described as an adjunctive approach rather than an exclusive treatment within itself. This comparatively conservative view may foretell the establishment of hypnosis (or certain of its features) finally as a legitimate and accepted psychotherapeutic adjunct rather than a recurring fad.

Hypnosis has been applied in a variety of ways for psy-

chiatric difficulties. It is used for simple relaxation or "placebo" effect for any condition in which there is apparent emotional tension. Direct symptom removal through suggestion is its oldest and most time-honored use; this approach, without an understanding of psychodynamics and without an overall psychotherapeutic program, has been considered of potential danger. It has been used for the direct suggestion of the disappearance of attitudes or inculcation of new ones or for exploring underlying problems and conflicts. An important usage has been for the purpose of abreaction and emotional catharsis of traumatic experiences. Specialized hypnotic techniques like age regression or automatic writing are considered helpful in stimulating the production of dreams or eliciting conflictual material. These techniques are considered a means of obtaining a rich source of material for further psychotherapeutic work. The hypnotic trance is sometimes incorporated into desensitization treatment of phobias or other psychoneurotic conditions by the behavior therapists. Finally, hypnoanalysis has been developed as a special aid in psychoanalysis, essentially as a means for overcoming resistances, again an adjunctive use of the method.

The depth of hypnosis obtainable and therapeutic results have not positively correlated. Like other psychologic methods of treatment, hypnosis has not been accurately evaluated; follow-up studies will be necessary to assess its final practicability as a treatment procedure in psychiatry.

Complications

Danger has arisen most likely from the indiscriminate application of hypnosis, developing partially from lack of understanding of the hazards attending its use. In this respect, two fundamental characteristics of hypnosis as ordinarily practiced will be mentioned since they are apparently important sources of clinical difficulty.

First, in the state of hypnosis, the subject has a heightened capacity to remember otherwise repressed material. It may be that the narrowed attention to outside stimuli make for more in-put "channels" for internal stimuli (i.e., memory). In this state of reduced ego defensiveness a breakthrough of traumatic memories can overwhelm the individual resulting in uncontrollable degrees of anxiety with accompanying clinical manifestations which may reach a degree qualifying for

a psychiatric diagnosis. It is a clinical impression that awareness of this complication gives considerable protection against it. Ordinarily, it would seem, the confidence arising from the relationship with the hypnotist offers security against this potential side effect.

Second, the dependency of the subject on the hypnotist can be intense and regressive in nature, and, in fact, is characteristically so; this may offer complications again if the hypnotist is not aware of this possibility. This and other transference complications (i.e., displacement or projection of highly affect-laden old internalized parental-like images on to the hypnotist) are probably no different from those arising in any psychotherapeutic encounter and, indeed, in any intense two-person relationship, of which the doctor-patient one is an example.

Summary

Hypnosis is a state of mind in which a subject is in an altered state of consciousness characterized by a narrow and select focus of attention with partial "voluntary" hypersuggestibility and relinquishment of ego control to a hypnotist. The hypnotist may use a variety of direct and indirect procedures to effect a hypnotic trance in a subject or to deepen such a trance; some subjects can learn to induce a trance in the absence of a hypnotist.

Hypnosis has been found useful for the relief of pain and anxiety in a number of medical and surgical settings; in psychiatry it is used for symptom relief, attitude changes, and insight giving.

Complications may be minimized by understanding the psychodynamic and interpersonal features of hypnosis.

(Bibliography on request from author.)

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Kindergartens and Mental Health

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Project Head Start, inaugurated at approximately 13,400 centers in 2,500 communities of the United States during the summer of 1965, indicated the urgent need for more kindergartens and nursery schools in all parts of the nation. Describing the project, an article in *Time* (July 2, 1965) stated:

> In eight weeks this summer, Head Start will try to make some headway against the sad fact that too many children are not emotionally, psychologically or physically ready to bridge the gap between crowded, repressive homes, where they are told to shut up, and the public school, where they are asked to open up and learn. The project puts kids of four, five, and six into "child development centers," where under close personal attention they will be encouraged by simple successes to avoid the spiral of failure that often starts with school's first day. They will have physical examinations, dental care, free meals. Their parents will be counseled at home, urged to help the kids by such easy steps as reading to them and telling them stories.

An earlier statement in the *Newsletter* of the American Psychiatric Association (April 1965) described Operation Head Start as a nursery school program for four to five-year-olds and went on to say, "It is probably the most massive effort ever to be undertaken in the field of prevention of emotional disorders. It will, in effect, offer a mass screening facility for the early detection of trouble in the emotional growth and development of the deprived children."

After Project Head Start had been completed, an article on education in the *New York Times* (Sept. 5, 1965) observed:

> The United States last week took a historic step toward the extension of school by at least two years, beginning at age three or four instead of the traditional five or six. This may be the eventual effect of President Johnson's announcement that Project Head Start, introduced this year as a short-term summer program for under-privileged youngsters, will be turned into a permanent part of the educational system.

Project Head Start, a part of the national anti-poverty program, was designed to reach and benefit young children from underprivileged homes, but a number of children were enrolled from homes where there was no economic poverty. From a mental health standpoint economic status is not the only criterion of need for preschool education. There are a multitude of children who are overprotected or emotionally neglected in the "vacant," disturbed, or broken homes of the middle and upper economic strata of society. The purpose of this article is to point out that children, regardless of socio-economic status, can profit by organized programs before they reach the age of six.

The age of the child at which public schools should take responsibility for education remains a debatable topic. Since forty-two states have provision for public school kindergartens, it is obvious that schooling for five-year-olds is generally accepted. In a personal letter from the National Education Association (June 15, 1965) it was stated, "The U. S. Office of Education published a study showing enrollments in each grade as of the fall 1963. This indicated that there were no children enrolled in public kindergartens in the states of Alabama, Arkansas, Mississippi, North Carolina, West Virginia, Idaho, and New Mexico." This information does not mean that all the public schools in the other forty-two states are operating kindergartens, but it does indicate that these states have taken positive action to provide preschool education and to safeguard the children from poor programs.

According to the U. S. Department of Health, Education, and Welfare, Office of Education, Bulletin 1964, No. 11: "Seventeen States authorize local schools to establish nursery schools and to use their own funds for this purpose. Thirteen States give local school boards authority to use both State and local funds for nursery schools." This information indicates a fair acceptance of the idea that the school starting age should be around three.[1]

The writer will resist the temptation to include discussion of nursery schools in this article. Before considering facts

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[1] In the book, *Twentieth Century Mental Hygiene (1950)*, the writer contributed a chapter entitled "The Contributions of Mental Hygiene and the Future." After pointing out that there is a partial vacuum in mental hygiene activities between the neonatal period and the time a child enters school at age six or sometimes almost seven, the statement was made: "It is predicted that eventually public school systems will extend their sphere of influence downward to the two year level—not for educational purposes in the usual sense, but as a contribution to mental health. State and national assistance, financially and in other ways, will be necessary."

about the need for kindergartens, a review of some of the historical points about them is in order.

The German word "kindergarten," meaning a garden of children, was first used by Friedrich Froebel in 1840 as the name of the school founded by him in Blankenburg, Germany. This institution was designed to meet the educational needs of children between the ages of four and six. The success of Froebel's demonstration led to the establishment of kindergartens in other countries, and by 1875 there were kindergartens in Great Britain, Holland, Belgium, Switzerland, Japan, Canada, and the United States.

It is recorded in the Encyclopaedia Britannica that the first kindergarten in the United States was opened during 1856 in Watertown, Wisconsin. A German immigrant couple started the school for German-speaking children, including their own. However, credit for the founding of the kindergarten movement in this country must be given to Miss Elizabeth Peabody. She was ably assisted by her sisters, Mary (Mrs. Horace Mann) and Sophia (Mrs. Nathaniel Hawthorne). In fact, Mary Peabody, before her marriage to Horace Mann, went from Salem to Boston in 1839 to open a school for very little children—particularly five-year-olds. The school was not called a kindergarten at that time, and it ceased to exist after her marriage to Horace Mann because the couple had a long honeymoon in Europe where they studied the latest educational programs. After her husband's death Mary Mann opened a school for little children in Concord and shortly thereafter, in 1860, Elizabeth Peabody started a kindergarten, "like Mary's," in Boston on Pinckney Street.

In 1867, Elizabeth Peabody visited kindergartens in Germany and other European countries. On her way home she was instrumental in establishing the English Froebel Society and when she arrived home she started the Froebel Union in the United States. From then on until her death in 1895, Miss Peabody crusaded through the country in the interest of kindergartens, as her friend, Dorothea Dix, had crusaded for the mentally ill.

The year was 1880 when Mary Mann, writing about her experiences as a teacher and about her husband's strong faith in education, said, "It is not enough to cultivate the memory or even to enlighten the understanding. Out of the heart are the issues of life . . . . The introduction of the

kindergarten is the first step, for the heart of the little child must be secured before it is corrupted by the world—and all other things can be added in due time."

The first kindergartens were available for children of the well-to-do who could afford the tuition fees or for children of immigrant laborers through philanthropic support. To encompass all children and bring kindergartens under public school responsibility and financial support, new state laws had to be enacted. The first states to pass such laws—Connecticut, Indiana, and Vermont—did so in the 1880s. These laws and those enacted subsequently by other states usually included provision for special training of kindergarten teachers in state-supported colleges. However, without a state law the first inclusion of kindergartens in a public school system occurred in St. Louis, Missouri in 1873. Almost a hundred years later (1963) the Bureau of the Census reported that about fifty-four per cent of the five-year-old children in the United States were enrolled in kindergartens (forty-four per cent public, ten per cent private).

Regardless of the existence of kindergartens for over a century, many people are opposed to any kind of schooling before a child reaches the chronological age of six or over. The writer has often heard remarks such as: "Don't push the little dears." "Let them enjoy the freedom of childhood while they can." "Why should they be regimented so early in life?" "They learn too much and become bored in the first grade." One mother refused to send her only child, a five-year-old with a mental age of almost seven, to kindergarten because she thought the girl would learn too much and become inattentive and mischievous in the first grade.

Some of the most cogent reasons for the provision of kindergartens for all children are to be found in the studies of Arnold Gesell. About fifty years ago Gesell established scientific evidence that in the first six years of life there is three times as much mental development as occurs in the next two sexennia. In other words, there is three times as much mental development before a child enters the first grade as happens between the ages of six and eighteen, the school yars. In his book, *The Mental Growth of the Pre-School Child* (1925), Gesell compared the rate of mental growth to the obviously decelerating rate of physical growth. Some of his observations made at that time are as follows:

> It has even been suggested that sixteen years ordinarily marks the end of the period of intellectual development. The pre-school development, however, holds an unambiguous and undisputed preeminence in the dynamic series. *It comes first.* This priority confers upon it a dominating influence. . . . The basic lines of both physical and mental organization are laid down during the formative pre-school years. How could it be otherwise? . . . What is true of general physical development is true of mental and nervous development. The brain grows at a tremendous rate during the pre-school age, reaching almost its mature bulk before the age of six. . . . The mind develops with corresponding velocity. The infant learns to see, to hear, handle, walk, comprehend, and talk. He acquires an uncountable number of habits fundamental to the complex art of living. Never again will his mind, his character, his spirit advance as rapidly as in this formative pre-school period of growth. Never again will we have an equal chance to lay the foundations of mental health.

Gesell and other students of neonatal and preschool development have been aware of the immaturity of the human infant, and of the need for protection and nurture during the exterogestational first year of life. Coincident with this has been the awareness of the very rapid growth of the brain as indicated by Gesell. At birth the average brain volume is 350 cc; at one year it is 800 cc; at three years it is 1,250 cc; while the brain volume for the adult is 1,400 cc. Also, the cortex of the brain reaches its maximum thickness before the age of two. Obviously, the brain structure is ready for education long before the age of six.

Recently, students of child development have said that half of all growth, physical and intellectual, takes place before the age of five, and the next thirty per cent occurs between five and eight. Also, there is a growing consensus of opinion that a stimulating and challenging environment during the very early years leads to a faster rate of mental development which is reflected in a higher adolescent and adult level of intellectual capacity.

Although it is generally considered that the teaching of the three Rs should not start until the child is in the first grade, evidence is accumulating which shows that the average

child can start learning to read, spell, calculate, and write at the age of three or four. In the latter half of the 1950s Dr. O. K. Moore carried out basic studies that led to the production of the "talking typewriter." It has been demonstrated that with this device a three-year-old can learn the alphabet and then progress to recognition of words and sentences with production of stories before he is six. Dr. C. H. Delacato and his associates have produced instructions and equipment for parents to teach preschool children to read. Reports from these and other sources indicate that the children thoroughly enjoy the process of learning during these early years.

Going hand in hand with physical and intellectual growth is the social-emotional development of the child. This term, "social-emotional," expresses the concept of a process which pertains to growth needs within the child and in relation to people about him. From the standpoint of mental health it is the most essential phase of growth. As in physical and intellectual development, the pace is very rapid in the formative years.

The neonate is a very helpless and selfish animal. His biological needs with regard to eating, sleeping, and eliminating are satisfied pronto with help from others for whom he has no consideration. He cries for food at any hour of the day or night, and he wets or soils ad lib. Rather quickly the outside world calls for some adjustments. He has to give up some of his insistent selfish desires; make time adjustments; be regimented more and more; and eventually adapt to the desires and rights of other people. The weaning from breast or bottle is a paradigm for a continuing process of weaning from emotional dependency on mother.

Within the very young child there is a progression of changes from the initial narcissistic state with its numerous avenues of satisfaction through oral and anal stages to a more definite genital orientation. The mother is or should be the first external love object, but sometimes this relationship is continued too long by mother, child, or both. On the other hand, when a mother is not present or does not fulfill her functions, the process of relating to others may be retarded. Gradually, the father and siblings play important roles in the emotional maturation of the young child. Long before the age of six the child should stop hanging onto mother's apron strings; should be able to get along with his peers; and

should give up the more infantile ways of living.

In psychoanalytic terminology, the parts of the personality called the ego and the superego are usually well developed before the age of six. Ego development implies the establishment of the child's identification of himself as an individual apart and different from others. Also, the ego must gain some conscious control over the primitive impulses. The superego is essentially our conscience. Freud said that the superego is formed from the introjected ideals and principles of behavior absorbed from those in a position of authority, particularly the parents, during the early life of the child. The instillation of the superego has many aspects of a "brain washing" process, and as the old Jesuit said, "Give me the child until he is six and I care not who has him thereafter."

From the above information about the growth of the brain, the intellectual development, and the personality maturation it appears evident that there is need for all children to have planned educational activities from the age of two or three. Our public schools should provide the main avenue for meeting this need. This does not mean that the public schools would supplant the worthwhile kindergartens and nursery schools now in existence, but it does mean that control of standards for kindergartens and nursery schools should be vested in a state educational authority in order to protect against subminimal services.

Moreover, if we had kindergartens and nursery schools for all children, many physical, intellectual, and emotional problems would be revealed at an earlier age when remediation is more hopeful. The large number of physical disorders revealed through Project Head Start attests to the validity of this statement. Along with preschool physical examinations psychological studies should be provided for all children in order to have a broad-gauge estimate of their general intellectual capacity and some leads about special abilities or disabilities. Before children enter the first grade those who are mentally retarded should be known and steps should have been taken to meet their needs. Incapacities in speech, hearing, and vision (including color vision) should be diagnosed as early as possible. Also, it is possible to predict which children may have a reading disability before they enter the first grade. All of these incapacities can be revealed in kindergartens where remedial steps can be taken.

The White House Conferences on Children and Youth, held in 1950 and 1960, advocated nationwide education of preschool children. The recommendation of the Conference in 1960 was: "That kindergartens be made an integral part of the tax supported school system in all communities; and that State departments of education be authorized to extend public education to include nursery schools."

At state level certain legislatures have failed to take the action required for the establishment of public school kindergartens. Some of this inertia may be due to lack of knowledge or prejudice, but the excuse for inaction usually centers around lack of funds. However, revenues are found to support other educational projects which may be not so important as preschool education. Kindergartens are expensive, but studies indicate that funds expended in providing kindergarten experience for all children would be repaid in the future well-being of these young citizens. The question is no longer, can we afford to have public school kindergartens, but can we afford not to have them.

Total Health for the Total Man

Robert B. Reeves, Jr.

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Through most of Western history, from the second century to the early twentieth, we believed that man was made up of two orders of reality: physical and spiritual. And we divided his care between those who looked after his health and those who watched over his salvation. Sometimes we used the word "health" for both, but still distinguished between physical health and spiritual health, and believed that medicine and religion dealt with different parts of man's being. On the whole, the division was tidy. We knew where we stood, and by-and-large kept out of each other's hair.

But that era is gone. I doubt anyone would venture now to make a sharp distinction between the physical and spiritual, or would regard such an attempt as anything but brash. Too much has happened in the last 50 years. Let me point up some of the significant developments.

First, modern psychology and psychosomatic theory have profoundly affected both medicine and religion. I imagine every physician here has often had to deal with the emotional problems of a patient, employing psychotherapy, or even going beyond that to explore a patient's values and motivations, very much as a father confessor! For example, one of our eye surgeons, operating on a woman for detached retina, found she was so tense that she required an unusually high amount of anesthetic. The surgery failed. Before operating again, he, and the chaplain, each spent some hours helping the patient work through her anxieties. At the second operation, which was successful, less anesthetic was required than for any other patient in the doctor's experience. He said to me afterwards, "I don't know whether I'm a surgeon or a priest—sometimes I wish I could stick to the practice of medicine!"

Psychology and psychosomatics have broken through the boundary between the realms of flesh and spirit. And through this breach the physician has been drawn over into concern for the emotions, the mind, and often the soul of his patient,

and the minister has been drawn over into concern for the patient's anxieties, the success of his surgery, his bodily well-being. To the doctor's remark, the chaplain might well have added, "And I don't know, either, whether I'm practicing medicine or religion!"

Let me give another example. One day a minister came to me for help in dealing with a woman who was, as he put it, "insanely pious." Whenever he called at her home, she insisted he pray, not just once before leaving, but three or four times during the visit. He felt this was a bit extreme, and asked how he might kind of calm her down. I asked for more information, and learning that she was extremely hirsute and somewhat bulgy-eyed, suggested he get her to come in for a check-up. Eventually she had glandular surgery, and now, the minister reports, she is less hairy, less bulgy-eyed, and does not ask for prayer at all. He is not sure whether to thank me or not. And I am not quite sure what this illustrates, except that here again the old dividing wall between things spiritual and physical has come tumbling down.

Not only have the boundaries in our practice been breached, but also the theoretical foundations for those walls have been destroyed. If we start with the terms "body" and "mind," we have just three choices. First, we can take them as separate orders of reality, and try to relate them, as dualism has tried. Descartes brought them together in the pineal gland, but neither he nor anyone else has ever explained how they could interact. Both on logical and psychosomatic grounds, such efforts are a contradiction-in-terms.

Or second, we can make body a derivative of mind, as the philosophical idealists and the Christian Scientists do, saying that mind is the only reality, and the body is simply an appearance spun out by the mind to clothe itself. "It's all mental." Everything at root is "psychogenic." I do not think in this company I need take the time to argue that view down.

Or third, we can make mind a derivative of body, as the materialists and mechanists do, saying that body or matter is the only reality, and mind is simply a function or efflorescence of it. (Homer Smith gave eloquent expression to that view in his book, *From Fish to Philosopher.*) Such people are very suspicious of the word psychosomatic, and insist it should be spelled the other way around, "somatopsychic." What they

usually mean is "somatogenic." Matter is primary, mind is secondary.

But materialism and mechanism have two basic shortcomings. One is that they overlook great chunks of evidence, drawn from both common experience and scientific observation, confirming the reality of psychosomatic phenomena. I refer you to any of the standard texts such as Engel or Weiss and English. And the second shortcoming is that the concepts on which materialism and mechanism are based, the idea of matter as "stuff," and of the machine as model for living processes, are no longer tenable. The physical sciences no longer know what matter is, and talk instead of quantum theory and the principle of indeterminism. And instead of the machine being model for the biological and behavioral sciences, it is now the other way around: the living organism is the model and the machine is regarded as an oversimplification. (A few weeks ago I read a transcript of the NASA Conference on problems of survival in space, held at Princeton in October, and I found the physicists and engineers looking to the biologists and neurophysiologists to show the way. I realized again how far behind we had left the machine as model for living man.)

So long as we try to start with "body" and "mind," we are stuck. No matter what we do with those two terms, we cannot get out of them an adequate theoretical basis for psychsomatic phenomena. We have simply got to break with the use of those terms as starting points, and start instead with man, the living organism, in the totality of his being. This, I believe, is the real impact of psychology and psychosomatics, the way they have forced us to re-think our presuppositions. We may not know where we are coming out, but we do know that dualism, idealism, and mechanistic materialism are none of them the answer.

In spite of this development, many people, especially in religion, are trying to hold on to the idea of the soul as an entity. They say, "Very well, mind and body may, indeed, be completely interrelated—but there is still a spiritual part of man that is independent of the mind and body, and that will always be the domain of religion. We stand on the Judeo-Christian faith."

But here we must face another development that has come in these last 50 years: the recovery, through Biblical studies,

of what the Scriptures really say about the being of man. The original meaning of many of the Hebrew and Greek words in which the Bible was written has been obscured in our English translations. The English language is a product of nineteen centuries of dualistic thinking, determined largely by the victory in the second century of late Greek, or Neo-platonic, doctrine over the Hebraic and early Greek thought behind the Biblical texts. Our English words, "body," "soul," "flesh," "spirit," as we use them, to designate separate orders of reality, have no counterparts in Biblical Hebrew or Greek. The words which we so translate, *beten, nephesh, basar, ruach, soma, psyche, sarx, pneuma,* in the Bible are used interchangeably to denote the total being of man. Wherever any one of them is used, any of the others could be substituted without change in meaning. Similarly, the distinction we make in English between physical health and spiritual salvation has no parallel in the Biblical languages. In the Old Testament the words *yeshuah* and *shalom,* and in the New Testament *soteria,* are used to denote both health and salvation, and wherever they occur the context makes it plain that total well-being is meant, without distinction between physical and spiritual. Further, nearly every Biblical word for what we would call a psychic state is derived from the word for a bodily organ or function, usually visceral. The most familiar is the derivation of "love" or "compassion" from the word for "bowels." "To love" originally is "to have a rumbling or churning of the bowels." There are many other such derivations. The locus of psychic life in the Bible is the gut.

Thus, in the light of its original languages, the Bible sees man as a single earthy reality, mortal, one with all the rest of created nature. Man is unique, not because he is made any differently from other creatures, but because God chooses to enter into a convenant with him. The "image of God" which is stamped on man is not substantive, but a relational mark of distinction.

When Neo-platonic thought won out in the early Church, those original Hebrew and Greek meanings were lost. In their place came the dualistic idea of man as an eternal and transcendent soul temporarily housed or imprisoned in an earthly and mortal body. The image of God concept was applied substantively to the soul as an entity, man's psychic functions were intellectualized and elevated, and the body was

relegated to inferiority as of a lower order, part of bestial nature. The health of the body and the salvation of the soul were divorced. Medicine took care of the body, religion the soul. Since all the Latin and English translations of the Bible presupposed such a dichotomy, it is no wonder we lost sight of the original meanings. But Biblical scholarship now has taken the ground out from under the idea that the soul is an entity, and has joined hands with psychology and psychosomatics to insist upon the unitary character of man's being.

So here we are. We are *in* each other's hair, and the distinctions by which a hundred years ago we might have got ourselves sorted out, are gone. For better or worse, each of us, physician and clergyman, has been forced over a little way into the other's territory, and there are no markers by which to set up the old boundaries again. We are faced with the necessity to work out new lines of demarcation.

Three things are needed. One is a unifying concept that will make sense of the behavior of the human organism, a theoretical basis for the idea of total man and total health. The second is a redefinition of our areas of concern, a new statement of what medicine and religion are about. And the third is the development of guide lines whereby we may mark off our distinctive roles and functions. This is a tall order, and I can only make some rather tentative suggestions. If I seem to state things more strongly than evidence warrants, please remember that at this point I have said a word of caution.

For a unifying concept, we can probably find no better springboard than Edmund Sinnott's little book, *Cell and Psyche,* (first published in 1950, and now out in paperback as a Harper Torchbook. It is perhaps the finest brief review in print of the implications of biology and biophysics for the understanding of man). He develops two main arguments. First, "the fact of *organized* growth and activity, leading to the production and maintenance of those self-regulating structures . . . called organisms, is the most distinctive feature of living things." And second, "this biological organization, on the one hand, and desire, purpose, and the higher phenomena of mental life, on the other" (p. 75), are both manifestations of the same underlying life process. The organized process is the *given.* Both body and mind are derivatives of it. They are not independent realities, and neither one of them is primary. They are simply two faces of a single coin, different ways of

describing the organized process. The way to understand man is to study the process, at every level and from the viewpoint of every discipline in both the sciences and the arts.

Among the disciplines to which Sinnott urges we look for clues is bioelectrics. This is obviously not my field, but as an amateur I have been reading widely in it. A great deal of the material has been reviewed by Robert Becker in the *New York State Journal of Medicine*. The direction in which this work points is toward the concept of an energy continuum, in which every aspect of organic and inorganic nature is related electromagnetically. In the human being, the full range of man's physical, emotional, mental, and spiritual activity is seen to be in continuity, from cell growth right on through to an act of prayer, all dynamically interrelated in an on-going process of energy transfer.

Among the problems so far studied are the origin of life on earth, the transfer of the energy of foodstuffs into the energy of muscle activity, the coding of DNA, the change in cell growth from an oxidative process in healthy tissue to a fermentative process in tumors, variations in the level of exciteability in nerve tissue, fluid transport in plants, orientation of flatworms, tissue regeneration in salamanders, reduction of tumors in mice, inhibition and stimulation of ovulation in mice, stimulation of bone growth, hypnosis, sleep, coma, anesthesia, periods of aggravation and remission in schizophrenia, admissions to mental hospitals, the teaching of the deaf and dumb to speak, and many more. In all of these areas electromagnetics appears to provide a unifying clue to what is going on. It may be—and this, I repeat, is tentative—that we have here the basis for many psychosomatic processes that up to now have remained mysterious. A great deal of work needs to be done, especially on the energy transfers involved in thought and feeling, but from the direction in which research is moving, I believe we shall one day be able to demonstrate the continuity of energy transfer throughout the whole range of man's growth and behavior.

Let us move on to the problem of redefining what medicine and religion are about. If all aspects of growth and behavior are in a continuum, on what basis do we differentiate areas of concern? If, as the Bible indicates, health and salvation are the same, why not merge medicine and religion, as primitive peoples have always done, and let us all be physician-priests?

If for no other reason, we have to differentiate because there is too much going on for any one profession to comprehend it all. But beyond the need to divide up the work, there are differences in the levels and modes of expression of the life process, which require specifically appropriate training, skills, vocabularies, social structures, and value systems in the people who investigate them. Granted, we are all concerned with the total health of the total man, yet in any given case, say for example, the case of a patient whose leg has been mashed in an automobile accident, there are many levels and modes of approach, and each calls for very specialized understanding. Most directly engaged is the orthopedic surgeon who puts the bits of bone together. He works at the level of repair of damaged structure. But supporting his work at another level and a very different mode is the researcher concerned with collagen formation in bone. And at another level, and again in a different mode, the psychiatrist attempts to find out why this patient crashes his car so often. And at still another level and mode, the minister deals with the patient's remorse and need for new motivation. The specificity of each approach requires a differentiation.

Yet they are all dealing with the same basic reality, the ongoing process of this man's life. And because all areas and levels of his life are in continuum, the effort of the specialist in each will have an effect in all the others. The researcher who finds ways to speed up collagen formation will simplify the surgeon's task, provide the patient with enough gain in healing to permit him to use psychiatry to the greatest advantage, and so indirectly give him enough boost in confidence to let him take a square look at his motives. And from the other end of the continuum, the minister, by helping the patient reorganize his values, may provide just the support he needs to get through a painful psychiatric experience, and by releasing the patient's remorse, may alter, perhaps, his electromagnetics, so that energy transfers take place which let him eat and sleep better, regularize his bowels, fight off infection, speed up collagen formation.

Here we can pick up again the terms we set aside a while ago. Once we take this unitary, dynamic, process view of man's being, we can speak of "mind" and "body" without danger of falling back into dualism.

Medicine, working primarily at the body end of the con-

tinuum, using drugs, surgery, radiotherapy, psychotherapy, helps a man function better at all levels of his being, including perception of goals, clarification of motives, liberation from conflict and depression, heightening of aspiration. Religion, working primarily at the mind end of the continuum, using sacrament, prayer, scripture, counseling, helps a man at all levels, including muscle tone, digestion, control of infection, endocrine secretion, healing of wounds. Let me illustrate both.

A male patient, who had asked for me, was extremely depressed, and could do nothing but go round and round and round a series of misfortunes that had jeopardized his job, his marriage, and his health. I reported to his internist, who agreed to call in a psychiatrist, who put the patient on an antidepressant drug. Four days later I was able to begin a series of talks with the patient that eventually led to his changing jobs, mending his marriage, and going back to church. Here, medicine, through a drug, opened the way to a reorientation of a man's outlook on life.

In another case, a woman who had been operated on for detached retina showed no signs of healing six days after operation. The doctor learned from the nurse that the patient seemed in a turmoil, and he asked me to see her. I spent an hour with her the 7th day, while she beat all around the bush, and an hour the 8th day, when she suddenly poured forth a poisonous stream of hatreds, jealousies, self-reproaches. We closed the visit, at her request, with prayer for forgiveness and grace. On the morning of the 9th day the doctor phoned me, "She's done eight days' healing overnight!" Here, religion, through confession and prayer, set off energy transfers and consequent biochemical changes that brought rapid healing.

And now, finally, the matter of guidelines whereby we may mark off our distinctive roles and functions. Most of what I have to say on this score is implicit in what I have said already. The first guideline, I believe, is: let the physician be a physician, and the minister a minister. Either vocation is enough to command a man's whole life, and either can be a sacred calling. But to try to combine them is to invite confusion in both oneself and the people one tries to serve, and is likely to produce mediocrity in one profession or the other, if not in both.

This has some very practical implications. One is that when

a minister makes sick calls in a hospital, or serves as a hospital chaplain, he should be dressed recognizably as a minister, and not in a doctor's white coat or jacket. I wear a "dog collar" when I am on duty; others may prefer a lapel insignia. Another implication is that the minister should not pull charts or make entries in them. He can learn everything that will be helpful to him by asking a doctor or nurse—and, incidentally, save all the time it would take to leaf through to find what he wants, and then decipher the handwriting, and then figure out what it all means anyway! And anything he needs to report, he can tell the doctor or ask the nurse to enter in her notes. A third implication is that with patients he avoid using medical language as he would the plague. And a fourth, that he strictly refrain from giving patients medical advice. These may seem very elementary, but it is amazing how often ministers appear to be trying to act like doctors.

There is not so much danger of the physician trying to act like a minister. And yet there is danger of the physician taking unto himself the making of decisions that involve a patient's ethical integrity and faith, as when, without consulting the patient's minister, he deprives him of opportunity to make his peace before he dies, or resorts to heroic measures without regard to a patient's style of life, or lets his interest in research override consideration of all other values. These practices, fortunately, are not the rule, but they occur often enough to be disturbing.

The second guideline may sound paradoxical: let physician and minister each learn everything he can about the other's work. The reason is this: as I showed at the beginning of my talk, both physician and minister are constantly being drawn into border areas of their competence, where they need to be especially alert for signs that the patient's trouble may lie primarly at the other end of the continuum. In the case of the depressed patient, if I had not known something about the clinical signs of depression, I might have prayed till doomsday with that man without doing him the slightest good—would probably have done great harm—but as it was, I caught the signs and took steps to bring in the psychiatrist whose special competence was needed. Likewise, in the case of the woman whose retina was not healing, if the doctor had not been alert to the signs of a guilty conscience, he might have performed all sorts of measures to no avail—and perhaps

have permanently damaged the eye—but as it was, he caught the signs and called me in for the special competence I had.

This is one of the reasons why, in the ministry today, we are putting so much emphasis on clinical training in hospitals. We do not want to be physicians or psychiatrists; we want to be good pastors and counselors, but to be good pastors and counselors in the border areas where so much of people's trouble is encountered, we need to know when and how to make referrals. We only wish there were as much concern among doctors to get clinical training in religion.

A third guideline, which is really a corollary of the second, is that physicians and ministers should be in continuing consultation. No matter what his specialty, a physician is dealing constantly with people whose ethical and spiritual values and goals affect the way they, as total organisms, handle the stresses of life. And the minister is serving people whose body chemistry and organ function affect the way they, as total organisms, handle the ethical and spiritual issues of life. A man cannot be healthy in one aspect of his being if he is sick in the other. Nor can he be saved, unless he is saved all the way through. Physician and minister each needs the other constantly looking over his shoulder. I have such a relationship with a physician. I throw my problems at him, and he throws his at me; and there is never a time we meet when we do not both of us gain in insight and effectiveness. We believe we are serving the total health of our patients.

Day Therapy, an Indication of Changing Attitudes in Psychiatry

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Establishment and rapid spread of psychiatric day hospitals as accepted programs of therapy has occurred in the last 20 years with the most rapid expansion occurring in the last decade. With the growing tendency to view this modality as bridging the gap between inpatient treatment and outpatient treatment and with the increasing emphasis on flexible comprehensive community mental health coverage, there is little doubt that this trend toward day programs will continue.

A great deal has been written about the advantages of day therapy (1,2,3) and some advocates estimate that from 50% to 75% of patients now treated as inpatients could receive as good or better care in day programs.

Some of these advantages are as follows:

1. Day programs offer more security and support than short outpatient visits but avoid fostering crippling dependency often seen after prolonged inpatient care.

2. Patients continue to live in family and community so that distorted relationships in these areas can be more readily evaluated and corrected.

3. There is less financial strain on the patient and his family or supporting community agencies because the day program requires only one shift of personnel and less use of beds and other costly inpatient facilities.

4. A one shift staff engenders a tightly knit team approach since the staff and patients do not encounter the difficulties in communication that occur with multiple shifts of personnel.

5. Personnel are better able to withstand the pressure of interacting with emotionally disturbed individuals since there are no rotating shifts or weekend coverage to interrupt their personal lives.

Of these advantages perhaps the greatest is the opportunity for the patient to daily utilize and evaluate in his family and community, techniques and attitudes learned in therapy. This allows time for a gradual change in attitudes of all concerned

as opposed to the rather abrupt and often threatening situation that occurs when the patient is discharged from an inpatient treatment program.

If there are many advantages in this type of program, one might ask why was it so long in coming to the fore? Why weren't these advantages apparent prior to the last 10 or 20 years? One can only speculate as to why these phenomena occur and the reasons for waxing and waning of therapeutic techniques. It would seem that changes in techniques result from subtle shifts in the philosophy of persons dealing with emotional problems. What then has brought about this proposed shift and what is the alteration in attitudes?

Perhaps the pressure of increasing numbers of individuals seeking help coupled with the relative lack of adequately trained personnel is leading to a more pragmatically oriented approach to therapy. There appears at present to be a growing trend to focus more on the interpersonal aspects of human behavior as opposed to previous emphasis on intrapsychic conflict. Few therapists in the field would intend to imply that difficulty in social living stems wholly from either one or the other of these aspects of human behavior. However, with the increasing emphasis on group activity, material for evaluation techniques used in interpersonal relationships is more easily accessible than material derived from the individual using the more time consuming method of a one to one patient-therapist relationship.

Goals of treatment seem to be shifting to, "When the patient learns to function adequately in his role in society he will feel better," instead of, "When the patient resolves his inner conflicts and understands his emotional problems he will be better able to function" (4).

At first glance this may seem little more than a play on words but this subtle change in attitudes has far reaching implications in the roles of individuals doing therapy and in the attitudes of patients to therapy situations. Implicit in this changing concept is a movement away from the classic medical model towards an educational model. In the medical model the therapist assumes responsibility for care of the patient who is presumed to have some type of internal sickness. In the educational model, individuals seeking help are encouraged to view their difficulty as stemming from learned inadequate techniques for relating to others. Here therapy teams are put

more in the role of directors in a laboratory where the patients maintain responsibility for learning and practicing new techniques of communication and social living.

Several day centers have reported the phenomenon of patients referring to the program as "classes" or "day school." The formal doctor-patient relationship is giving way to informal patient-staff interaction. This tendency to allow the patient to maintain responsibility is perhaps the prerequisite emotional climate that has fostered the growth of day programs and has dissipated staff aloofness engendered by custodial programs. Concomitantly more emphasis is being placed on the therapeutic effect of guided patient-to-patient relationships.

Although philosophies of various day programs are similar, therapeutic regimes vary widely not only from one unit to another but within the same unit from one time to another. This variation seems to depend on fluctuating attitudes of staff, patient population and staff-patient relationships. These variations are more apparent as one visits different day units than one might guess from the literature. The need for flexibility becomes evident as one observes fluctuations within a single unit.

Perhaps the following example will help to clarify this point. The Duke Psychiatric Day Unit was opened on February 1, 1965 after the staff visited several other day units in order to learn which techniques and facilities were necessary. The unit was established as a branch of the Duke Inpatient Service to be operated on the basis of patient fees, with a capacity of 12 patients. The initial staff consisted of a psychiatrist, psychologist, nurse, nurse's assistant, occupational therapist, two psychiatric aides, and a secretary-receptionist. The program was planned around a focus of group activities including: group discussions, group government, occupational therapy and classes in homemaking, dancing, auto mechanics, dramatics, etc. Although the unit had more than adequate staff, including volunteers and guest speakers, a limited amount of space made this rather comprehensive program somewhat impractical.

Space limitation has also led to careful screening of patient referrals, most of whom are from the higher socio-economic strata and not psychotic, with the more dynamically oriented less withdrawn patients being selected.

Shifting the program to meet the needs of this type of clientele has led to a rather specialized approach. For example, group discussion became more in demand while interest for occupational therapy and entertainment activities faded. As a response two psychiatric residents were added to the staff in place of the occupational therapist, attendants, volunteers, and guest lecturers. Structured group activity has given way to informal group discussion which now takes up 5 hours a day, 5 days a week.

In these discussions the focus is on interpersonal relationships and communication techniques. Individuals are helped to realize that much of their self-concept is based on the opinions of others and that these opinions stem from the method by which the individual expresses his needs and feelings. The prolonged time in intimate discussions and role playing situations helps the group and the individual to take inventory of their repertory of communication techniques. The focus on communication allows the group to say to an individual, "It's these techniques you're using that prevents you from accomplishing satisfying relationships, not you personally, because we can see that you are basically a nice person." This approach is much less threatening to the individual's identity and allows him to learn and try out new methods with less need for the sick role as a face-saving excuse.

The patients seem very receptive to this approach and attendance has been excellent. During the 7 months (135 operational days) that the unit has been open, there have been 82 patients for a total of 1226 patient days with an average of 9.4 patients per day. The length of stay ranges approximately from 2 weeks to 3 months.

Although at present referrals are often more than the space will accommodate, the program is geared at such an intensive level that it would probably not meet the needs of more disturbed withdrawn patients requiring a more prolonged stay and a supportive milieu.

Plans are now being made to expand the Duke Day Unit Program in an attempt to offer more comprehensive coverage. Several questions arise as to how to staff such a program. Will the enthusiasm engendered by the dynamic atmosphere of an intensive treatment program cause that part of the staff, who is responsible for the slower moving supportive program, to become bored because of "lack of results" or will

the supportive program generalize to include patients in whom support will engender further dependency? Can the same staff team cover both types of programs or should there be two teams? What criteria should be used to determine the program that will best fit the needs of a patient?

These are problems that continually arise in establishing or maintaining a flexible program of day therapy. It is becoming more apparent that day treatment programs vary just as widely if not more widely than inpatient treatment programs, depending on the attitudes of the people (staff and patients) involved.

In summary, it is felt that even though techniques used in day therapy vary from one unit to another, the recent evolution of day programs does indicate changing attitudes in psychiatry. These changes reflect the growing appreciation of how closely the needs of the individual are interrelated with the needs of his family and community.

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BOOK REVIEWS

HOLMES, DONALD J., M.D., *The Adolescent in Psychotherapy.* Little, Brown and Company. Boston. 1964. 337 pp. $9.50.

It is not too unusual to hear references made to the "unsuitability" of adolescents for various modes of psychotherapy, and perhaps for this as well as other reasons there does not seem to have been a great deal of any value written on the subject. The present book provides an exception, and the author goes far to demonstrate that the adolescent can often benefit greatly from treatment with a therapist who is willing to take into consideration those characteristics which make him different from either the child or the adult.

One of the most appealing characteristics of Doctor Holmes' book is its clear, unpretentious style, which compares favorably with the abstruse nature of many works of this type. The author depends more upon the richness of basic English than upon the jargon and jaded cliches favored by many medical writers; he thus manages to illuminate his subject rather than obscure it, and a reading of his book becomes an enjoyable experience rather than a necessary chore.

The title of the book reveals the author's basic approach to his subject. His first concern is with the adolescent himself—a challenging, often frustrating, and always fascinating individual, whether in our everyday contact with him or in psychotherapy. In both situations we often must dispense with the "usual rules" in recognizing and dealing with his uniqueness. Doctor Holmes, himself a veteran of many treatment encounters with adolescents, concerns himself with aiding us in always acting in the best interests of a patient who often seems bent upon frustrating our every effort to help him. We find that many of our comfortable and cherished techniques must give way before the necessity of viewing the process of therapy in ways to which we may not be accustomed. This need for flexibility, the author points out, may provide at least a partial explanation for the seeming paradox that while most of us profess an intense interest in the abstraction of "adolescence," many of us seem able to find ways to avoid dealing with the individual adolescent in therapy. The author makes it clear that whatever else he may be, the adolescent is often a very difficult patient.

The book itself is divided into several sections. The first of these, "Adolescents, Adults, and Psychotherapists," begins with a cogent discussion of the adolescent personality, its "strengths and weaknesses," and then moves into an elaboration of how these more or less generally applicable personality dynamics bear upon the treatment situation. The author attempts to establish some useful guidelines for differentiating "normal," age-appropriate behavior from "abnormal" mechanisms. This is an important consideration, for many of us who have dealt mostly with adults in therapy may have difficulty in distinguishing the adolescent's normal developmental struggles.

A later chapter in this section deals with modes of communication—particularly extraverbal communication—frequently employed by adolescents and just as frequently misunderstood by inexperienced therapists. Included elsewhere are valuable discussions of behavior control, and of defenses and resistances frequently seen in this age group.

In the next section of his book, that on "Individual Psychotherapy," the author puts these principles to work in illustrating the actual process of treatment with individual adolescents. Specific techniques of treatment, and how they differ from some of our more accustomed techniques, are discussed. As throughout the book, the text is richly supplemented by case material, presented with all the immediacy of the actual treatment situation and providing the reader with a view of the skillful therapist at work.

The final section of the book provides a timely study of the highly successful inpatient treatment program for adolescents at the University of Michigan Medical School. On this semi-open ward, a carefully constructed therapeutic milieu for disturbed and delinquent adolescents is combined with individual psychotherapy with unusually good results. This discussion of hospital treatment contains a wealth of experience and wisdom for anyone concerned with problems of selection and qualifications of staff, management of common group problems, and the application of psychotherapeutic principles to a "therapeutic community" in the hospital. There is a fascinating discussion of the evolution and prevention of so-called epidemics of group misbehavior, and exhaustive treatment of many other problems pertinent to milieu therapy. All in all, one is impressed that the author's optimism concerning the

possibility of providing such a treatment atmosphere in the hospital is borne out by his own experience. His guiding principle is "the conviction that the therapeutic milieu for anyone, and perhaps especially for children and adolescents, should be made to correspond as closely (as possible) to conventional, non-psychiatric group living situations," and he is able to provide us with some clear insights into how this may be done.

In summary, Doctor Holmes has written a highly readable book which should be invaluable to mental health workers of whatever discipline who are concerned with the management of adolescents in therapy. He has provided indispensable guidelines for all who have known the frustrations and the small triumphs of day-to-day psychotherapy with this difficult age group. He is less concerned with the specific "pathology" of the patient than with his desire—however deeply buried—for health, and occupies himself less with our hoary traditions than with our primary goal as therapists, which he states clearly as "attempting to represent reality as accurately as possible to the patient. . . . It is the touchstone of the process, and should dominate the therapist's intentions in everything he says to the patient in any situation."

Thomas E. Buie, Jr., M.D.

HENDRICK, IVES, M.D. *Psychiatry Education Today.* International Universities Press, Inc. New York. 1965. vii + 108 pp. $3.00.

Those who share concern for the professional education of psychiatrists will find this essay by Ives Hendrick a heartening and even exciting experience in reading. Heartening because Dr. Hendrick finds a way straight to the heart of the matter and exciting because he develops with beautiful lucidity the consequences for educational practice that follow from a clearly and simply stated grasp of the problem.

Beginning with a brief recounting of the generally little known origins of dynamic psychiatry during the first quarter of this century, Dr. Hendrick moves to delineate his basic and orienting principle: the definition of dynamic psychiatry as one of the basic sciences of medicine. Grounding his argument in the best of empirical scientific tradition, Dr. Hendrick states, "Dynamic psychiatry is *basic* in the same sense

as the other medical sciences; it originates in an area of observations which other basic sciences do not study." Delineating these areas of observation to include behavior, symptoms, thought, emotion, mood and other mental experience he concludes "that this definition of psychiatry as a 'basic science' should be the cardinal principle of deliberate and intelligent construction of a program of professional education in psychiatry."

Before undertaking discussion of the principle subject of his essay, Dr. Hendrick deals briefly with the teaching of basic psychiatry to medical students. He makes a well-grounded plea for an educational reform that has long been universally accepted in other sciences. "The laboratory," he states, "is indispensable for teaching chemistry and physics, the case method for teaching medicine. Observation depends upon techniques, and to learn techniques at first hand they must be practiced." Thus a teaching program would best achieve its primary purpose by insuring "maximal opportunities for each student to sample, while working with his patients, that kind of clinical facts from which are derived those generalizations and abstractions of dynamic psychiatry and psychoanalysis which so many today have previously 'tape-recorded' in their minds."

The longest chapter and the heart of his essay is a thoughtful and thought-provoking discussion of the architecture of a teaching program for psychiatry residents. In this chapter educational conviction and program construction are brought into focus. The logic of Dr. Hendrick's convictions lends meaning and guidance to the working day of teachers and students. Here thrown into bold-relief is the contrast between programs and practices based on conscious, deliberate internal consistency and those that simply grow by accretion. Previously stated guiding principles are applied to the difficult tasks of deciding in each of the many and now rapidly changing instances the "morticing" of educational goals and individual interests, of true learning and clinical assignments. The elements of a basic clinical program and the place in such programs of associated biological and sociological sciences are thoroughly explored. In discussing the much disputed place of research in basic psychiatric education, we are cautioned of the possibility that its true purpose of enriching and broadening the resident's comprehension is all too often lost when it comes

before "his psychiatric development is adequate for mature appraisal of clinical data, and his psychiatry research is therefore scientifically useful."

In a separate chapter dealing with the subject of psychotherapy and resident education we are similarly cautioned that too early and too intense involvement in long-term psychotherapy poses a special problem of education in "requiring that knowledge be applied before the resident has acquired it." As in the instance of research assignments the place of formal, long-term psychotherapy must not be at the expense of the time required for realization of the residents' primary purpose "to become expert in the fundamentals."

Dr. Hendrick is a psychoanalyst and psychiatric educator of long experience. Since 1943 the ideas presented in this essay have evolved and been constantly tested against his experience teaching medical students and psychiatric residents in the Harvard Teaching Unit at the Boston Psychopathic Hospital. He shows a deep sensibility of the individuality of students, teachers and clinical settings. His lucidity and clarity of conviction and purpose are blended on every page with recognition of uncertainties in face of the necessity to teach and learn a changing science and art of psychiatry. We are privileged to have the substance of his knowledge and experience for he is clearly a man who knows his subject deeply and cares greatly for the future of psychiatric education. Those who share his concern, students and teachers alike, would search long for a better means to meet their mutual interests and obligations than studying his essay. It is warmly recommended.

Granville Tolley, M.D.

The Psychiatric Unit in a General Hospital, ed. KAUFMAN, M. R., M.D., International Universities Press, Inc. New York. 1965.

With the increased trend toward community mental health programs there has been a concomitant increase in general hospitals with psychiatric units or psychiatric programs. This book is an excellent compendium of thoughts and ideas presented by thirty different mental health professionals, each with experience in his topic area. The book is divided into six sections, each divided further according to specific topics and concluded with a discussion by the participants.

Section I, entitled "The Setting and Its Personnel," deals with facilities and personnel, giving descriptions and information of help to anyone attempting to set up a psychiatric unit. Section II is entitled "The Patient" and reviews the type and rationale for use of facilities housing different kinds of programs and types of patients. Section III is entitled "Therapeutic Programs" and reviews standard therapeutic approaches as well as specific problems of treatment of alcoholic, drug addicted, child, adolescent, and geriatric patients. In this section there is also consideration of certain social and legal implications of general hospital psychiatric units. Section IV covers training and education programs in connection with the psychiatric unit especially regarding psychiatric residents, interns, residents on other services, non-psychiatrist physicians and disciplines other than physicians. Section V consists of a chapter by Dr. Roy Grinker on the research potentials of general hospital psychiatric units. He points out the potential for research in the clinical area and especially of observation of the patient in his total life situation. Section VI is entitled "Impact" and describes the relationship that the psychiatric unit has on other segments of the hospital and community.

This book presents much practical content for anyone involved in or thinking of a psychiatric unit in a general hospital. It is a book that should be read by anyone and certainly any physician or psychiatrist involved in a community program. Furthermore, it is a book which should be included in any residency training program in psychiatry.

N. E. Stratas, M.D.

Notice to Contributors

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References to books and journals should be numbered consecutively in a bibliography at the end in the order in which they appear in the manuscript. References should be limited to those used by the author in the preparation of the article and kept to a minimum.

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